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HOSPITAL SERVICES MANUAL APPENDIX

SECTION I - INTRODUCTION

I. INTRODUCTION

A. Introduction

This edition of the Kentucky MedicaidProgram Hospital Services Manual has been formulated with the intention of providing you, the provider, with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will assist you in understanding what procedures are reimbursable and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.26 might be replaced by new pages 7.26 and 7.27).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning agency policy shall be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services shall be directed to the Division of Program Services, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-7759. Questions concerning billing procedures or the specific status of claims shall be directed to EDS, P.O. Box 2009, Frankfort, Kentucky 40602, or Phone (800) 756-7557or (502) 227-2525.

B. Fiscal Agent

Effective December 1, 1983, Electronic Data Systems (EDS) began providing fiscal agent services for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

The physical location for EDS is:

EDS
2545 U.S. 127 South
Frankfort, KY 40601

II. KENTUCKY MEDICAID PROGRAM

A. General

The Kentucky Medicaid Program is administered by the Cabinet for Human Resources, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U. S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services provided to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medicaid Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that the Department for Medicaid Services is bound by both Federal and State statutes and regulations governing the administration of the State Plan. The Department cannot reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered, unallowable medical services.

The Kentucky Medicaid Program, Title XIX, Medicaid, is not to be confused with Medicare. Medicare is a Federal program, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. Coverage, will be specified in the body of this manual in Section IV.

B. Administrative Structure

The Department for Medicaid Services within the Cabinet for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. The Department for Medicaid Services makes the actual payments to the providers of medical services, who have submitted claims for services within the scope of covered benefits which have been provided to eligible recipients.

Determination of the eligibility status of individuals and families for Medical Assistance benefits is a responsibility of the local Department for Social Insurance offices, located in each county of the state.

c. Advisory Council

The Kentucky Medicaid Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of eighteen (18) members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining seventeen (17) members are appointed by the Governor to four-year terms. Ten (10) members represent the various professional groups providing services to Program recipients, and are appointed from a list of three (3) nominees submitted by the applicable professional associations. The other seven (7) members are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three (3) months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five (5) or six (6) member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees is decided by the professional organization that the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

D. Policy

The basic objective of the Kentucky Medicaid Program is to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulate that Title XIX Programs have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medicaid Program is payor of last resort. Accordingly, the provider of service shall seek reimbursement from third party groups for medical services provided. If you, as the provider, receive payment from the Medicaid Program before knowing of the third party's liability, a refund of that payment amount shall be made to the Medicaid Program , as the amount payable by the Department shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating. providers shall provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap, or age.

Each medical professional is given the choice of whether or not to participate in the Medicaid Program. From those professionals who have chosen to participate, recipients may choose the one from whom they wish to receive their medical care.

When the Department makes payment for a covered service and the provider accepts the payment made by the Medicaid Program in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and. no bill for, the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient.

Providers of medical service attest by their signatures (not facsimilies) that the presented claims are valid and in good faith. The submission of fraudulent claims is punishable by fine or imprisonment.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky.

The provider's adherence to the application of policies in this manual is monitored through either post-payment review of claims by the Department, or computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual remains in effect and thus the claims become subject to post-payment review by the Department.

Medical records and any other information regarding payments claimed shall be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection or copying by Cabinet personnel. Records shall be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit exception or other dispute.

All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services to recipients of this Program shall be on a level of care at least equal to that extended private patients, and normally expected of a person serving the public in a professional capacity.

All recipients of this Program are entitled to the same level of confidentiality accorded patients NOT eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical speciality.

All services are reviewed for recipient and provider abuse. Willful abuse by providers can result in their suspension from Program participation. Abuse by recipients may result in surveillance of the payable services they receive.

Claims shall not be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, claims shall not be paid for services that required, but did not have, prior authorization.

Claims shall not be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall attach to the Cabinet and no bill for the same service shall be paid by the Cabinet.

E. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment or any part thereof to a use other than for the use and benefit or such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more.than $25,000 or imprisoned for not more than five years of both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a

State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly *or* indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services,

(C) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(D) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

F. Timely Submission of Claims

Claims for covered services provided to eligible Title XIX recipients shall be received by the Medicaid Program within twelve (12) months from the date of service in order to be reimbursed. Claims received after that date will not be payable. This policy became effective August 23, 1979.

According to Federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months of the Medicare adjudication date. Federal regulations define "Timely submission of claims" as received by Medicaid "no later than 12 months from the date of service." Received is defined in 42 CFR 447.45 (d) (5) as follows: "The date of receipt is the date the agency received the claim as indicated by its date stamp on the claim." For Kentucky, the date received is included within the Internal Control Number (ICN) which is assigned to each claim as it is received at EDS. The third through the seventh digits of the ICN (e.g. 9889043450010 = February 12, 1989) identify the year and day of receipt, in that order. The day is represented by a Julian date which counts the days of the year sequentially (January 1 = 001 through December 31 - 365/366). To consider those claims 12 months past the service date for processing,

the provider shall attach documentation showing timely RECEIPT by EDS and documentation showing subsequent billing efforts. Claim copies are not acceptable documentation of timely billing. A maximum of twelve (12) months can elapse between EACH RECEIPT of the aged claim by the Program.

Claims for Title XVIII deductible and coinsurance amounts can be processed after the twelve-month time frame if they are received by the Medicaid Program within six (6) months of the Medicare disposition.

G. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which, as an adjunct to the Kentucky Medicaid Program, provides certain categories of medical recipients with a primary physician or family doctor. Only those Medicaid recipients who receive medical assistance under the Aid to Families with Dependent Children (AFDC), or AFDC-related categories are covered by KenPAC. Specifically excluded are: the aged, blind, and disabled categories of recipients; nursing facilities, intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD); and mental hospital inpatients; foster care cases; all spend-down cases; and all Lock-In cases. To aid in distinguishing from regular Medicaid Program recipients, the KenPAC recipients will have a green Medicaid Program card with the name, address, and telephone number of their primary care provider.

Primary physician specialists or groups who can participate as primary physicians are:

General Practitioners	Obstetricians	Primary Physician Clinics
Family Practitioners	Gynecologists	Primary Care Centers
Pediatricians	Internists	Rural Health Clinics

Recipients can select a primary physician or clinic who agrees to participate in Medicaid and KenPAC. Recipients not selecting a primary physician will be assigned one within their home county. A primary physician can serve up to 1,500 patients for each full-time equivalent physician. Primary Care Centers and Rural Health Clinics can also be assigned recipients based on the number of Registered Nurse Practitioners they have on staff.

KenPAC primary physicians or clinics shall arrange for physician coverage 24 hours per day, seven days per week. A single 24 hour access telephone number shall be provided by the primary physician or clinic. This number will be printed on the recipient's KenPAC Medical Assistance Identification Card.

The following service categories shall be either provided by the primary physician or clinic or referred by the primary physician or clinic in order to be reimbursed by the Medicaid Program.

Physician (excludes Ophthalmologists, Psychiatrists, obstetrical services and routine newborn care billed using the mother's MAID number)
Hospital Inpatient and Outpatient (excluding psychiatric admissions and routine newborn care billed using the mother's MAID number)
Laboratory Services
Nurse Anesthetists
Rural Health Clinic Services
Home Health
Primary Care Centers
Ambulatory Surgical Centers
Durable Medical Equipment
Advanced Registered Nurse Practitioners

Services not included in the above list can be obtained by the KenPAC recipient in the usual manner.

Referrals can be made by the KenPAC primary physician or clinic to another provider for specialty care or for primary care during his or her absence. Special authorization or referral form is not required and referrals shall occur in accordance with accepted practices in the medical community. To ensure that payment will be made, the primary physician or clinic shall provide the specialist or other physician with his or her Medicaid Program provider number, which is to be entered on the billing form to signify that the service has been authorized. With the primary care physician's approval, his or her provider number can be relayed by a referred specialist or institution to other specialists or institutions.

Claims for services provided to KenPAC recipients which do not have a referral from their primary physician shall not be paid by the Medicaid Program.

"Emergency Care" is defined as a condition for which a delay in treatment can result in death or permanent impairment of health.

Pre-authorization from the primary physician is not required for emergency care. The primary physician shall be contacted, whenever practical, to be advised that care has been provided, and to obtain the physician's authorization number. If the authorization cannot be obtained from the primary physician, the provider shall contact the KenPAC Program to obtain an authorization number before submitting a claim.

"Urgent care" is defined as a condition not likely to cause death or lasting harm, but for which treatment shall not wait for a normally scheduled appointment (e.g., suturing minor cuts, setting simple broken bones, treating dislocated bones, and treating conditions characterized by abnormally high temperatures).

The primary 'physician shall be contacted for prior authorization of urgent care. If prior authorization is refused, any service provided to the client shall not be payable by the Kentucky Medicaid Program. If the recipient's primary physician cannot be reached for prior authorization, urgent care is to be provided and the necessary authorization secured after the service is provided. Under this circumstance, if post-authorization is refused by the primary physician or the primary physician cannot be contacted after service has been provided, special authorization can be obtained from the KenPAC Program. When the Program determines that the special authorization procedure is being misused, the individual provider will be advised that special authorization for further services can be refused.

Routine care in the emergency room is not to be authorized by the primary physician, and shall not be payable under the Program; however, the primary care physician may authorize a brief examination in the emergency room in order to determine if an urgent care situation exists, even if the patient is subsequently determined as a result of the examination to require only routine care.

KenPAC primary physicians and clinics, in addition to their normal fee for service reimbursements from Medicaid, will be paid $3.00 per month for each KenPAC patient they manage. Maximum monthly reimbursement shall not exceed $3,000.00 per physician. Any questions about the KenPAC Program shall be referred to:

KenPAC Branch
Division of Patient Access and Assessment
Department for Medicaid Services
275 East Main Street, Third Floor East
Frankfort, KY 40621

Information and special authorization numbers can be obtained by calling toll free 1-800-635-2570 (In-State) or 1-502-564-5198 (In- or Out-of-State).

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

A. Appropriate Certification

1. Acute care hospitals shall be licensed by the state and certified for participation under Title XVIII of Public Law 89-97 (Medicare) in order to be eligible to submit a Commonwealth ofKentucky, Cabinet for Human Resources, Department for Medicaid Services Provider Agreement (MAP-343 Rev. 5/86), Department for Medicaid Services Certification on Lobbying (MAP-343A), and Department for Medicaid Services Provider Information Form MAP-344 (Rev. 03/91) to the Medicaid Program. Hospitals participating in the Kentucky Medicaid Program are required to meet the current conditions of participation for hospitals, HIR-10 (Rev. 6/67) governing participation under Title XVIII of Public Law 89-97, and amendments thereto. In those instances where higher standards are set by the Medicaid Program, these higher standards will also apply.

   An applicant shall not bill the Medicaid Program for services provided to eligible recipients prior to the assignment by the Medicaid Program of a provider number. The Medicaid Program will not assign a provider number until all forms required for the application for participation are completed by the applicant and returned to the Department for Medicaid Services and it is determined that the applicant is eligible to participate. Once an applicant is notified in writing of an assigned provider number, the Medicaid Program can be billed for covered services provided to eligible recipients.

2. Certification for participation under Title XVIII will not be required of hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

3. Any hospital wishing to terminate its agreement shall submit this in writing to the office of the Commissioner, Department for Medicaid Services. Any services provided to recipients by the hospital as of the date of that hospital's termination will not be reimbursable by the Medicaid Program.

4. If a provider wishes to submit EMC claims, the provider shall complete and submit a Provider Agreement Addendum (MAP-380 Rev, 4/90). If a third party computer billing agency is used to prepare the media for the provider, the electronic media billing agency shall also complete and submit an Agreement (MAP-246 Rev. 10/86). These completed forms shall be mailed directly to the Department for Medicaid Services, Provider Enrollment, 275 East Main Street, Frankfort, Kentucky 40621.

5. The Department for Medicaid Services has authorized payment for services provided July 1, 1987, and after to eligible Medicaid recipients in Medicaid-certified dual-licensed beds, in accordance with KRS 2168.107. Please refer to your Nursing Facility Services Manual for detailed information.

6. If a provider wishes to bill the Medicaid Program for hospital-based physicians, the hospital shall complete the Certification of Conditions Met (MAP-346) and the Statement of Authorization (MAP-347). The MAP-347 shall be completed and retained in the hospital's files and the MAP-346 shall be completed and submitted to the Medicaid Program prior to billing for any physician services. Without the completion of these forms, a hospital will be submitting fraudulent claims.

   This same procedure will also apply to all hospital providers that are billing the Medicaid Program for physical therapy and speech therapy services.

B. Out-of-State Hospitals

Out-of-state hospitals can automatically participate in the Medicaid Program if they are participating in their own. state's Title XIX program. They shall forward to the Medicaid Program a completed Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services Provider Agreement (MAP-343) and Provider Information form (MAP-344). If they do not participate in their own state's Title XIX Program, they shall be certified to participate in the Title XVIII Program. They shall then forward a completed MAP-343 and MAP-344 to the Medicaid Program.

Out-of-state hospitals shall also provide to the Medicaid Program a current notice of continuing certification of participation in their state's Title XIX Program. If not, Kentucky Medicaid participation shall be terminated in accordance with the expiration date of the original participation agreement.

Out-of-state hospitals on binding review with a Medicaid Peer Review Organization (PRO) in their state shall review all Kentucky Medicaid admissions for medical necessity before payment can be made. All bills submitted for payment by hospitals on binding review shall verify this by completing form locator 87 on the UB-82 claim form.

Hospitals not on binding review with a Medicaid PRO are to perform utilization review in accordance with their state's utilization review guidelines. Verification that the utilization review mechanism of the hospital reviewed the admission will be accomplished by completing form locator 87 on the UB-82 claim form.

Hospitals will be required to submit additional information if requested by the Program.

C. Out-of-Country Hospitals

Hospitals located outside the United States and Territories cannot participate in the Kentucky MedicaidProgram.

D. Peer Review Organization (PRO)

The Professional Standards Review Organization (PSRO) was established in 1972 by Public Law 92-603 and later changed to Peer Review Organization (PRO). The primary purpose of the PRO is to assure that services provided to Title XIX recipients are medically necessary and at the appropriate level of care.

Emergency admissions do not require pre-admission review but admission review is to be performed -within two (2) working days of said admissions. The authorized length of stay (LOS) will be determined, for these types of admission, during admission review.

Scheduled admissions require pre-admission review which shall be obtained by the office staff of the admitting physician. The pre-authorization number and length of stay (LOS) assigned by the PRO shall be provided. to the hospital by the admitting physician.

If the recipient received a backdated Medical Assistance Identification Card showing retroactive eligibility, the hospital staff can call the PRO for review of the service. This needs to be completed immediately after the card is received by the recipient.

LOS extension requests shall be initiated by hospital staff by contacting the PRO staff at the toll-free number.

The PRO office can be contacted at 1-800-292-2392 In-state or 1-800-228-5762 (In or Out-of-State) between the hours of 8:00 a.m. and 5:30 p.m. (Eastern Standard Time on Monday through Friday).

Address inquiries regarding PRO procedures to:

Healthcare Review Corporation
9200 Shelbyville Road
Suite 215
Louisville, KY 40222

E. Termination of Participation

If a provider's participation is terminated by the Kentucky Medicaid Program, services provided after the effective date of termination are not payable.

SECTION III - CONDITIONS OF PARTICIPATION

907 KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medicaid Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;

2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;

3. Misrepresenting factors concerning a facility's qualifications as a provider;

4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or

5. Submitting false or questionable charges to the agency.

The Kentucky Medicaid Program shall notify a provider in writing at least thirty (30) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice will state:

1. The reasons for the decision;

2. The effective date;

3. The extent of its applicability to participation in the Medical Assistance Program;

4. The earliest date on which the Cabinet will accept a request for reinstatement;

5. The requirements and procedures for reinstatement; and

6. The appeal rights available to the excluded party.

The provider receiving such notice may request an evidentiary hearing. The request shall be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker aooointed by the Secretary for Human Resources. When an evidentiary "hearing is held, the provider is entitled to the following:

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;

2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;

3. Counsel representing the provider;

4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and

5. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of the Cabinet for Human Resources. These procedures apply to any provider who has received notice from the Cabinet of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Kentucky Medicaid Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medicaid Program. Adverse action taken against a provider under Medicare shall be appealed through Medicare procedures.

SECTION III - CONDITIONS OF PARTICIPATION

F. Placement

Assistance with placement in nursing facilities can be obtained by contacting the local office of the Department for Social Services whose staff are knowledgeable regarding potential for placement in Kentucky facilities.

The Medicaid Program does not routinely make payment for services provided to Kentucky Medicaid recipients who are placed in out-of-state long term care facilities, e.g. nursing facilities (NF), intermediate care facilities for the mentally retarded and developmentally disabled (ICF/MR/DD) and mental hospitals.

G. Patient's Advance Directives

Effective December 1, 1991, Section 4751 of OBRA 1990 requires that adults eighteen (18) years of age or older receive information concerning their rights to make decisions relative to their medical care. This includes the right to accept or refuse medical or surgical treatment, the right to execute a living will, and the right to grant a durable power of attorney for his or her medical care to another individual.

A hospital shall give information regarding advance directives at the time of the individual's admission as an inpatient. Additionally, providers shall:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

(b) Provide written information to all adult individuals on their policies concerning implementation of these rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State law (whether statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

State law allows for a health care provider or agent of the provider to object to the implementation of advance directives. For additional information, refer to KRS 311.634 and KRS 311.982 or consult an attorney.

Please refer to Appendix XXI for copies of materials relating to the Advance Directive Law.

1) Description of Kentucky laws regarding the

a) Living Will Act
b) Health Care Surrogate Act
c) Durable Power of Attorney

2) Living Will Declaration

3) Designation of Health Care Surrogate

4) Advance Directive Acknowledgement

5) Protocol

The cost of reproducing these materials shall be Medicaid allowable cost for Medicaid-eligible individuals.

SECTION IV - PROGRAM COVERAGE

IV. PROGRAM COVERAGE

A. Inpatient Services

1. A maximum of fourteen (14) days per admission is payable for admissions on and after April 1, 1981. All admissions are subject to approval by the Medicaid Peer Review Organization (PRO), and shall be within the scope of covered services. The Medicaid Program pays for either the date of admission or the first day of eligibility, if later, but shall not pay for the date of discharge; however, all covered ancillary charges incurred on the date of discharge shall be allowed by the Medicaid Program.

   Effective July 1, 1989, the Kentucky Medicaid Program provides reimbursement, without durational limits, for medically necessary inpatient hospital services provided to Medicaid recipients under age one (1) in hospitals defined by the Department of Medicaid Services as disproportionate share hospitals. This means that for disproportionate share hospitals, recipients under age one (1) shall not be limited to the regular maximum of fourteen (14) days. After age 1, coverage reverts to the 14 day maximum.

   Effective for services provided on and after July 1, 1991, by hospitals designated by the Kentucky Medicaid Program as disproportionate share hospital, recipients. under age six (6) are eligible for medically necessary inpatient services without durational limits, regardless of any prior utilization of hospital services. After age 6, coverage reverts to the 14-day maximum.

   Effective for services provided on and after July 1, 1991, the Kentucky Medicaid Program shall provide reimbursement for medically necessary inpatient services, without durational limits, regardless of any prior utilization of prior services, for recipients under age one (1). Reimbursement is available irrespective of designation as a disproportionate share hospital. After age 1, services provided by non-disproportionate share hospitals reverts to the 14-day maximum.

Effective for services provided on and after March 4, **1991,** hospitals are reminded that KRS 205.575 requires hospitals participating in the Hospital Indigent Care Assurance Program **(HICAP)** to provide medically necessary days of care in excess of Medicaid program limits to Medicaid recipients free of charge to the Medicaid Program or the recipient. **HICAP** only applies to inpatient hospital services provided to recipients by hospitals located within the state of Kentucky.

2. Inpatient admissions covered for eligible Program recipients are those primarily for treatment indicated in the management of any acute or chronic illness, injury, or impairment, and for maternity care.

3. Admissions for diagnostic purposes shall be reimbursable only if the diagnostic procedures cannot be performed on an outpatient basis.

4. The Medicaid Program shall make payment for Program recipients who are transferred from a greater facility to a lesser facility for a combined total of 14 benefit days.

   Reimbursement for admissions to the lesser facility shall be subject to the policies and procedures governing all admissions to acute care hospitals.

   The Medicaid Program shall make payment to the greater acute care hospital for a maximum of 14 days for Program recipients who are transferred from a lesser acute care hospital to a greater acute care hospital, if the needed acute care cannot be provided at the "lesser" facility.

5. The Medicaid Program shall make payment for readmissions within 30 days ONLY when an acute exacerbation of an existing condition occurs or when an entirely new condition develops.

6. The General Assembly, Regular Session 1978, passed legislation (House Bill 179) which amended KRS 205.560. The law specifies the conditions for which the Medicaid Program can make payment for induced abortions, induced miscarriages, or induced premature births for Title XIX recipients. The services shall be considered covered, subject to other Program edits, if the physician certifies that in his or her professional judgement an induced abortion or miscarriage is necessary for the preservation of the life of the woman, and in the case of an induced premature birth, intended to produce a live viable child.

   The appropriate certification forms (MAP-235 or MAP-236), indicating the procedure used and signed by the physician, shall accompany all invoices requesting payment for these services.

7. Sterilizations shall be reimbursable by the Medicaid Program only when in compliance with federal regulations (42 CFR 441.250) which are as follows:

   a. The consent form (MAP-250, Rev. 1/79) shall be signed by the recipient and the person obtaining the consent at least thirty (30) days in advance of the procedure being performed, except in cases of premature delivery and emergency abdominal surgery, in which cases only a seventy-two (72) hour waiting period is required. The expected date of delivery shall have been 30 days in advance of the date the consent was given. A maximum of one hundred and eighty (180) days shall elapse between the date the consent form is signed and the date on which the procedure is performed.

   b. The physician who performs the procedure shall sign and date the MAP-250 after. the sterilization procedure is performed.

   c. The recipient shall be at least twenty-one (21) years of age at the time consent is obtained.

d. The recipient shall not have been legally declared mentally incompetent unless he or she has been declared competent for purposes which include the ability to consent to sterilization, and shall not be institutionalized. The fact that a facility is classified as an NF or ICF/MR is not necessarily determinative of whether persons residing therein are "institutionalized." A person residing in an NF or ICF/MR is not considered to be an "institutionalized individual" for the purposes of the regulations unless that person is either: (a) involuntarily confined or detained under a civil or criminal statute in one of those facilities; or (b) confined under some form of a voluntary commitment, and the facility is a mental hospital or a facility for the care and treatment of mental illness.

e. The recipient shall be advised of the nature of the sterilization procedure to be performed, of alternative methods of family planning, and of the discomforts, risks, and benefits associated with it. The recipient shall be advised that his or her consent to be sterilized can be withdrawn at any time and will not affect his or her entitlement to benefits provided by Federal funds.

f. Interpreters shall be provided when there are language barriers and special arrangements shall be made for persons with disabilities.

g. To reduce the chances of sterilization being chosen under duress, a consent shall not be obtained from anyone in labor or childbirth, under the influence of alcohol or other drugs, or seeking or obtaining an abortion.

h. These regulations apply to medical procedures performed for the purpose of producing sterility.

i. Reimbursement shall not be available for hysterectomies performed for sterilization purposes.

j. ALL applicable spaces of the MAP-250 shall be completed and the form shall accompany all claims submitted for payment for a sterilization procedure.

a. In those cases where a sterilization is performed in conjunction with another surgical procedure (e.g., cesarean section, cyst removal) and compliance with Federal regulations governing payment for the sterilization has not been met, the Kentucky Medicaid Program can only make payment for the non-sterilization procedure. It is necessary to disallow one-half of the following: operating room charge, anesthesia charge, and pathology charges. Hospitals which utilize an all inclusive rate reimbursement system shall deduct one (1) day's charges representing Room and Board and All Inclusive Ancillary Services. These charges shall be entered in the non-covered column of the UB-82 billing form, indicating non-payment for the actual sterilization procedure. In the event a sterilization procedure is performed concurrently with a delivery and compliance of the sterilization procedure with federal regulations is not documented, the disallowed components will be the total operating room charges and all other ancillary charges pertaining to the sterilization procedure. The delivery service is payable if the patient is an eligible recipient.

9. Title XIX funds can be expended for hysterectomies that are medically necessary only under the following conditions:

a. The person who secures the authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render her permanently incapable of reproduction; and

b. The individual or her representative, if any, has signed and dated the Hysterectomy Consent Form (MAP-251, Rev. 1/79).

This Hysterectomy Consent Form (MAP-Xl, Rev. 1/79) shall accompany all claims submitted for payment for hysterectomies, except in the following situations:

a. The individual is already sterile at the time of the hysterectomy; or

b. The individual requires a hysterectomy because of a life-threatening emergency in which the physician determines that prior acknowledgement is not possible.

The physician shall certify in writing either the cause of the previous sterility or that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgement was not possible. The physician shall also include a description of the nature of the emergency. This documentation shall accompany any hysterectomy procedure for which a Hysterectomy Consent form (MAP-251) was not obtained.

If the service was performed in a period of retroactive eligibility, the physician shall certify in writing that the individual was previously informed that the procedure would render her incapable of reproducing, or that one of the exempt conditions was met.

10. Private accommodations shall be reimbursed by the Medicaid Program only if medically necessary and so ordered by the attending physician. The physician's orders for and description of reasons for private accommodations shall be maintained in the recipient's medical records. If a private room is the only room available, payment will be made until another room becomes available. If all rooms on a particular floor or unit are private rooms, payment will be made. Documentation of these cases shall be made available to the Program upon request.

11. Physical therapy is an aspect of restorative care which consists of the application of a complex and sophisticated group of physical modalities and therapeutic services to relieve pain, develop or restore functions, and maintain maximum performance. The Medicaid Program will make payment for these services (as an ancillary service) when the therapy is actively concerned with restoration of a lost or impaired function. For example, physical therapy treatments in connection with a fractured hip or back, or a CVA shall be directed toward restoration of a lost or impaired function during the early phase when physical therapy can be expected to be effective. After the condition has passed the acute phase and the medical services provided in a hospital are no longer needed, the need for physical therapy will not justify continued hospitalization. These services can be provided through the outpatient department of the hospital or in an extended care facility.

    a. Physical therapy shall be prescribed and directed by the attending physician.

    b. Physical therapy shall be provided by a licensed physical therapist *or* a registered physiotherapist.

    For purposes of general information and clarification, when a patient is receiving supervised exercises while receiving hospital care for conditions not involving impairment of a physical function, the services required to maintain him or her at a given level generally shall not constitute physical therapy services, and therefore, shall not qualify for reimbursement by the Medicaid Program. General supervision of exercises which have been taught to the patient also shall not qualify for payment by the Medicaid Program. These services shall constitute rehabilitative nursing care and shall be included in the administrative cost of the facility.

    These definitions apply to both inpatient and outpatient hospital care.

The hospital administrator is required to complete an MAP-346 and MAP-347 notifying the Medicaid Program that the facility has these therapists on its staff. The MAP-347 shall be retained in the hospital's file and available for review by the Medicaid Program staff. The MAP-346 shall be submitted to the Medicaid Program any time the staff is changed. Mail to: Department for Medicaid Services, Provider Enrollment, 275 East Main Street, Frankfort, Kentucky 40621.

NOTE: Physical therapy services provided off-site in accordance with provisions of the Commission for Health Economics Control in Kentucky, are reimbursable only to licensed, participating rehabilitation hospitals.

12. Newborn hospital charges are billed on a separate claim from the mother's (baby's name and MOTHER'S Medical Assistance number are entered on the claim form). These services shall be billed to the Medicaid Program using Type of Bill 110 which represents a non-payment or zero pay bill. This applies to instate hospitals only. All out-of-state hospitals shall bill the Medicaid Program using TOB 111 because they are reimbursed at a percent of usual and customary charges without year end cost adjustment.

Effective for services provided prior to July 1, 1991, if it is determined to be medically necessary (certified by PRO) for the newborn to stay after the mother is discharged, payment may be made for a maximum of fourteen days after the mother's discharge. The baby shall be eligible for the Medicaid Program benefits and the service shall be billed under the baby's name and Medical Assistance number. The date of service will begin with the date of the mother's discharge.

Effective for newborn services provided from July 1, 1989 through June 30, 1991, to recipients in hospitals defined by the Department of Medicaid Services as disproportionate share hospitals shall not be limited to the fourteen (14) day maximum until age one (I). These services can be billed, without durational limits, for medically necessary inpatient hospital services beginning with the date of the mother's discharge. See Section VII for billing instructions.

Effective for services provided on and after July 1, 1991, if it is determined to be medically necessary for the newborn to remain in hospital after the mother's discharge, reimbursement shall be provided without durational limits until the recipient reaches age one (1) irrespective of designation as a disproportionate share hospital. The baby shall be eligible for Medicaid Program benefits and the services shall be billed under the baby's Medical Assistance number.

Effective for services provided on and after July 1, 1991, by hospitals designated by the Kentucky Medicaid Program as disproportionate share hospital, recipients-under age six (6) are eligible for medically necessary inpatient services without durational limits, regardless of any prior utilization of hospital services. See Section VII for billing instructions.

Payment cannot be made for hospital services when the baby is retained awaiting adoption placement because the continued stay is not medically necessary.

NOTE: If the mother was ineligible for Medical Assistance at the time of the service but the newborn has a Medical Assistance Identification Card, the charges for the newborn can be billed on a UB-82 using the baby's own number. In this type case, Form Locator four (4) of the UB-82 shall contain code 111.

13. Gastric bypass surgery and other similar procedures, including the jejunoileal bypass procedure and gastric stapling, are considered possibly cosmetic procedures and therefore are payable only if they meet the following criteria:

    a. There is documentation that the recipient suffers from other conditions to an extent dangerous to his or her health, e.g. high blood pressure, diabetes, coronary disease, etc.

    b. There is documentation that all other forms of weight loss have been exhausted, with legitimate efforts on the part of the physician and recipient, i.e. dieting, exercise, and medication.

    c. There is documentation that the sources of weight gain have been identified and subsequently, treatment was attempted in accordance with the diagnosis.

    d. There is documentation that prior to the surgery at least one (1) other physician besides the surgeon has been consulted and has approved of the surgical procedure as a last resort of treatment.

    e. The recipient is at least 100 pounds over the maximum weight of his or her height and weight category as determined by the attending physician.

    It is necessary that the above information accompany each claim for these procedures.

14. Billing for services prior to discharge may be made only if a recipient has been hospitalized for the applicable fourteen days of Program coverage. At that time, hospitals can submit an initial billing for the first fourteen days. After the recipient is discharged, the instate hospital can submit a final billing showing actual discharge date.

15. Admission kits.

16. Inpatient dental services for "high risk" recipients ONLY (those with heart disease, mental retardation, high blood pressure, etc.).

17. The Kentucky Medicaid Program recognizes the following durable appliances and supplies as covered items subject to audit as to medical necessity for appliance.

    Taylor Back-Brace
    Williams Back-Brace
    Chair Back-Brace
    Long Leg Brace
    Short Leg Brace
    Cervical Four-Poster Brace
    Shoulder Abduction Brace
    Lumbar-Sacro Corset
    Colostomy Care Devices or Permanent Appliances
    Ileostomy Care Devices or Permanent Appliances
    Prosthetic Care Devices - Contiguous Tissue
    Any Bag or Catheter Supply Necessary for the Day of Discharge
    Insulin Pump
    Jobst Garment
    TED Stockings

18. Per federal regulation (42 CFR 441.12), laboratory tests which are routinely performed on admission are reimbursable only when specifically ordered by the attending physician or responsible licensed practitioner.

19. A hospital can make arrangements or contract with others to furnish covered inpatient items and services.

    a. Where a hospital obtains laboratory or other services for its inpatients under arrangements with an independent laboratory, the laboratory shall be certified to meet the CONDITIONS FOR COVERAGE OF SERVICES OF INDEPENDENT LABORATORIES governing participation under Title XVIII of Public Law 89-97. In these cases where the Medicaid Program makes payment for hospital inpatient services provided to the recipient, receipt of payment by the hospital for those services (whether it bills in its own right or on behalf of those

furnishing the services) shall relieve the recipient and the Program of further liability.

b. When laboratory services are obtained for an inpatient of a hospital under arrangements with the laboratory of another participating hospital, receipt of payment by the first hospital for the services (whether it bills in its own right or on behalf of those furnishing the services) shall relieve the Program and the recipient of further liability.

c. Effective for services provided on or after September 1, 1992, any provider that bills the Medicaid Program for laboratory services shall be required to provide their Clinical Laboratory Improvement Act (CLIA) Certificate number.

20. Speech therapy is payable whenever it is prescribed and directed by the attending physician. The facility shall also have a licensed speech therapist on its staff. The Hospital Administrator is required to complete an MAP 346 and MAP-347 notifying the Medicaid Program that the facility has speech therapists on its staff. The MAP-346 form shall be completed and submitted to the Medicaid Program anytime the facility has a change in its staff. The MAP-347 shall be retained in the hospital's files and shall be available for review by the Medicaid Program.

21. For services provided prior to June **1, 1991,** observation room services and emergency room services are payable on an inpatient claim only when the recipient is admitted through the outpatient department.

22. Admissions strictly for treatment of alcohol, drug and chemical dependency do not fall within the scope of covered Medicaid benefits unless an emergency situation exists. In this event, discharge to an appropriate treatment center shall occur upon stabilization.

23. Hospital-based physician services (Anesthesiology, Cardiology, Pathology, Radiology, Encephalography) are reimbursable by the Department when billed in accordance with

Program guidelines. Please refer to Section V for detailed information.

B. Non-Covered Inpatient Services

1. Days of stay in excess of fourteen days per admission. This does not apply to acute hospitals that are billing Medicaid for recipients with exceptionally high costs or long lengths of stay under age one (1); and under age six (6) for disproportionate hospitals.

2. Days of stay in excess of the number of days set by PRO (subject to the fourteen day total limit).

3. If the recipient is "on leave" (not an inpatient), those days when he or she is not an inpatient are NOT to be counted toward the fourteen day period. Payment shall not be made for days when the recipient is "on leave."

4. Private duty nursing services.

5. Artificial limbs.

6. Personal services that are not medically necessary (examples: television, guest meals, telephone).

7. Any charge reflecting a service that is not a determined reimbursable cost by Title XVIII or Title XIX.

8. Late discharge fees.

9. Administratively necessary days as determined by the hospitals on binding review with the Peer Review Organization (PRO).

10. Services not within the scope of Program coverage regardless of PRO determinations.

11. Diagnostic admissions for procedures which could be performed on an outpatient basis.

12. Admissions for elective or cosmetic procedures are non-payable by the Medicaid Program. (If the attending physician feels the procedure is medically necessary, documentation to support the medical necessity shall be submitted to the Division of Program Services for consideration.

13. Routine physical exams.

14. Professional charges for physician services that are not hospital-based (Section V, Reimbursement).

15. Take-home drugs and supplies.

16. Occupational therapy.

17. Call back, stat and handling or processing fees, etc.

18. Observation room services and emergency room services covering services provided on and after June 1, 1991.

c. Outpatient Services

1. There are no limitations on the number of hospital outpatient visits or services available to Program recipients.

The hospital outpatient services which can be covered are as follows:

a. Diagnostic services as ordered by a physician

b. Therapeutic services as ordered by a physician

c. Emergency room services in emergency situations as determined by a physician. The recipient shall have contact with the physician.

d. Clinic visits, which are provided in an outpatient department owned and operated by the hospital, may be considered for payment. The clinic visit charge shall be billed separately and shall not include ancillary charges, blood tests, X-rays, etc.; therefore, any clinic visit charge shall be considerably less than an emergency room charge.

e. Minor surgical and radiological procedures.

f. Hospital-based physician services (Anesthesiology, Cardiology, Encephalography, Radiology, Pathology, Emergency Room physician) are reimbursable as defined in Section V, Reimbursement.

2. Sterilization procedures are payable as an outpatient service according to Federal Regulations cited in IV.A. - Inpatient Services.

3. Induced abortions, induced miscarriages, or induced premature births are covered as an outpatient service according to the regulations cited in IV.A. - Inpatient Services.

4. The following biological and blood constituents are exceptions to item D.3. and are PAYABLE in the outpatient department for services provided prior to July 1, 1990.

a. Rho (D) Immune Globulin (Human)
b. Anti-hemophilic Factor (AHF)
c. Rabies drug treatment
d. Chemotherapy for any blood or chemical dyscrasia (e.g. cancer, hemophilia)
e. Medications associated with renal dialysis treatments
f. Base IV solutions (without drug additives)
g. Tetanus toxoid
h. Cortison injections

Beginning with services provided on or after July 1, 1990, reimbursement is available for drugs administered in the outoatient department. Reimbursement is not available for take-home drugs **or drugs which have been deemed** less-than-effective **by the Food and Drug Administration (FDA).**

5. The hospital outpatient services listed previously shall be reasonable and necessary and related to the diagnosis and prescribed by, or in the case of emergency room services, determined to be medically necessary by a duly-licensed physician, or when applicable, a duly-licensed dentist, for the care and treatment indicated in the management of illness, injury, impairment or maternity care, or for the purpose of determining the existence of an illness or condition in a recipient. Moreover, the services shall be furnished by or under the supervision of a duly-licensed physician, or when applicable, a duly-licensed dentist.

6. A hospital may make arrangements or contract with others to furnish covered outpatient items and services.

   a. Where a hospital obtains laboratory or other services for its outpatients under arrangements with an independent laboratory, the laboratory shall be certified to meet the CONDITIONS FOR COVERAGE OF SERVICES OF INDEPENDENT LABORATORIES governing participation under Title XVIII of Public Law 89-97. In these cases where the Medicaid Program makes payment for hospital outpatient services provided to the recipient, receipt of payment by the hospital for those services (whether it bills in its own right or on behalf of those furnishing the services) shall relieve the recipient and the Program of further liability.

   b. When laboratory services are obtained for an outpatient of a hospital under arrangements with the laboratory of another participating hospital, receipt of payment by the first hospital for the services (whether it bills in its own right or on behalf of those furnishing the services) shall relieve the Program and the recipient of further liability.

   c. Effective for services provided on or after September 1, 1992, any provider that bills the Medicaid Program for laboratory services shall be required to provide their Clinical Laboratory Improvement Act (CLIA) Certificate number.

7. Physical therapy is covered on an outpatient basis according to the regulations cited for inpatient services - Section IV, item #11.

8. Speech therapy is payable whenever it is deemed as a necessity by the physician. Refer to regulations cited for inpatient services - Section IV, Item #20.

9. Outpatient dental services for "high risk" recipients ONLY (those with heart disease, mental retardation, high blood pressure, etc.).

10. Observation room and holding beds.

D. Non-Covered Outpatient Services

The following outpatient services shall be EXCLUDED from Program coverage:

1. Items and services which are not reasonable and necessary and related to the diagnosis or treatment of illness or injury, impairment or maternity care.

2. Services for which the recipient has no obligation to pay and for which no other person has a legal obligation to pay.

3. Drugs, biologicals and injectables purchased by or dispensed to a recipient for services provided prior to July 1, 1990, are not reimbursable by the Medicaid Program with the exception of those noted in C.4. (NOTE: These items may be provided under the pharmacy portion of the Medicaid Program, in accordance with the Medical Assistance Outpatient Drugs List.)

4. Routine physical examinations.

5. Charges less than $1.00.

6. Call back, stat and handling or processing fees.

7. Elective or cosmetic procedures are non-payable by the Medicaid Program. If the attending physician determines the procedure is medically necessary, documentation to support the medical necessity shall be submitted to the Division of Program Services for consideration.

8. Take home drugs and supplies.

9. Occupational therapy.

SECTION V - REIMBURSEMENT

V. REIMBURSEMENT

A. Reasonable Cost

The Medicaid Program shall pay for inpatient hospital services provided to eligible recipients through the use of rates that are reasonable and adequate to meet the costs that must be incurred as outlined in the Cabinet for Human Resources, Title XIX, Inpatient Hospital Reimbursement Manual. For any reimbursement issue or area not specified in the manual, the Medicaid Program shall apply the Medicare standards and principles described in 42 CFR Sections 405.402 through 405.488 (excluding the Medicare inpatient routine nursing salary differential).

Title XIX inpatient claims shall be paid at the per diem rate in effect on the first Medicaid covered day of admission.

B. Inpatient Rate

Each hospital shall be paid using a prospective payment rate based on on allowable Medicaid costs and Medicaid inpatient days. The prospective rate shall be all-inclusive in that both routine and ancillary costs shall be reimbursed through the rate. Hospitals may request an adjustment to the prospective rate with the submittal of supporting documentation. The established appeal procedure allows a representative of the hospital group to participate as a member of the rate review panel.

C. Outpatient Rate

Hospital outpatient services provided August 3, 1985, to July 1, 1988, shall be reimbursed at the rate of seventy (70%) percent of usual and customary charges. For services provided from July 1, 1988 through June 30, 1990, reimbursement for outpatient services shall be at sixty-five percent (65%) of the usual and customary charges. Laboratory procedures shall be paid in accordance with policy listed below. Charges or cost shall not be transferred between the inpatient and outpatient services units.

For outpatient services provided on and after July 1, 1990, reimbursement shall continue at sixty five (65%) percent of covered charges with limitations on reimbursement for laboratory services. The Department shall, however, cost settle to the lower of cost or charges at the year end for Kentucky hospitals.

Effective for services provided on and after June 1, 1991, all outpatient services provided prior to the actual time of admission shall be submitted on a separate claim and shall not be combined and billed as an inpatient service.

D. Outpatient Laboratory Rates

For services provided to Medicaid recipients on and after October 1, 1984, the Deficit Reduction Act of 1984 requires hospital outpatient and nonpatient laboratory services to be paid in accordance with a fee schedule. Where a tissue sample, blood sample, or specimen is taken by personnel not employed by the hospital but the sample specimen is sent to the hospital for tests, the tests are not outpatient services since the patient does not directly receive services from the hospital. These are nonpatient laboratory services. There will be a separate fee schedule for outpatient laboratory services and a separate fee schedule for nonpatient laboratory services. All outpatient and non-patient laboratory procedures shall be coded using the Current Procedural Terminology Fourth Edition (CPT-4).

All outpatient and nonpatient laboratory procedures other than those excluded by Medicare are subject to the fee schedule limitations. Payment shall be the lower of usual and customary charges or the maximum on the fee schedule. The fee schedule, developed by the Medicare carriers, is established on a carrier wide basis, not to exceed a statewide basis.

Separate charges made by hospital laboratories for drawing or collecting specimens are allowable up to $3.00, whether or not the specimens are referred to hospitals or laboratories for testing. This is payable to the hospital only when its staff extracts the specimen from the recipient. Only one collection fee is allowed for each patient encounter regardless of the number of samples drawn. A specimen collection fee will be allowed ONLY in the following circumstances:

1. Procedure Code P9600 or 36415

   Drawing a blood sample through venipuncture (Example: inserting a needle with syringe or vacutainer into a vein to draw the specimen). A specimen collection fee will not be allowed for blood samples drawn from a capillary.

2. Procedure Code P5367

   Collecting a urine sample by catheterization.

Neither deductible nor coinsurance will apply to either outpatient or nonpatient laboratory services paid under the fee schedule by Medicare. Payment in accordance with the fee schedule is payment in full.

The CPT-4 books may be ordered from the following address:

Order Department, OPO 54192
American Medical Association
P.O. Box 10950
Chicago, IL 60610

You may place your order by calling l-800-621-8335. Your checks are to be payable to the American Medical Association.

E. Hospital-Based Physicians

Reimbursement for services provided by hospital-based physicians (where applicable to the provisions of the Medicaid Program) shall be in accordance with the PRINCIPLES OF REIMBURSEMENT FOR SERVICES BY HOSPITAL-BASED PHYSICIANS, HIM-6 under Title XVIII of Public Law 89-97.

The reasonable cost for all professional services provided to the Medicaid Program recipients by residents and interns under professionally approved training programs is an item of reimbursable cost to the hospital. These services, therefore, cannot be billed separately to the Medicaid Program.

F. Professional Component of Hospital-Based Physicians

1. A physician is considered a hospital-based physician when he or she enters into a contractual arrangement with the hospital to provide a service for patients. The cost of salary or contract shall be recognized as a reimbursable cost by Title XVIII before it can be reimbursed by the Medicaid Program. The Medicaid Program applies the same definition to hospital-based physicians as does the Title XVIII Program as found in its PRINCIPLES OF REIMBURSEMENT FOR SERVICES BY HOSPITAL-BASED PHYSICIANS (HIM-6).

2. The Medicaid Program shall require that hospitals who bill the Program for services provided to their recipients by any or all of the hospital-based physicians maintain their records of the Medicaid Program payment on behalf of those physicians in a manner that the Program can obtain from hospital records exact information regarding amounts paid by the Medicaid Program on behalf of each physician.

3. The Medicaid Program shall make payment to the hospital for services of those physicians (for whom the hospital is billing the Medicaid Program) for professional patient care provided during and after the Program's covered hospital benefit days, This is the ONLY charge covered by the Program during days NOT payable by the Medicaid Program.

4. Only the following categories of practice (excluding emergency room physicians) are considered a reimbursable cost in which the professional component shall be reimbursed at 100% for services provided prior to July 1, 1988. Effective for services provided on and after July I, 1988, reimbursement for outpatient professional component charges (excluding emergency room physicians), shall be at 65% of usual and customary charges. The maximum payment for emergency room physician services provided prior to July 1, 1990 is $35.00. Effective for services provided on and after July 1, 1990, the maximum payment of $35.00 was removed and reimbursement shall be at sixty-five (65%) percent of the usual and customary charge.

Anesthesiology
Cardiology
Pathology
Radiology
Encephalography
Emergency Room Physicians (outpatient only)

These physicians shall meet all of the following criteria:

a. Shall be salaried or in contractual arrangements with the hospital

b. Shall be recognizable Title XVIII costs

c. Shall be licensed physicians in their states of practice

d. Reimbursement for professional patient care services provided by those hospital-based physicians in the categories listed in Section V.E.4. to Program recipients shall be made to the hospital in accordance with the rates of payment for professional patient care services established between the physician and the hospital in their mutual contractual arrangement. The Medicaid Program shall allow 100% of the professional charges for cost purposes on inpatient services; however, the Medicaid Program payment covering these services shall be included in the hospital's prospective rate of reimbursement. Outpatient professional services shall be reimbursed by the Medicaid Program at an interim rate of 65% of usual and customary charges with year end cost settlement to the lower of cost or charges. These physicians SHALL NOT bill the Medicaid Program for these services under any other Program element.

5. The hospital administrator signs an MAP-346 listing the hospital-based physicians and their license numbers. The physician then signs an MAP-347 authorizing payment to the hospital for his or her services outlined in the contract. The actual contracts shall be available for review by the Medicaid Program. The administrators maintain responsibility for keeping the list of hospital-based physicians updated and the MAP-347 shall be retained in the hospital's files. The MAP-346 shall be submitted to the Medicaid Program. prior to billing for the service.

6. The charge for an emergency room physician is not a recognizable charge on the inpatient billing form. If the recipient is admitted, the charge for an emergency room physician visit shall be submitted on a separate UB-82 billing form as an outpatient service.

7. a. The hospital shall bill only for those services provided to recipients actually seen and treated by a hospital-based physician. Records shall be audited and the hospital shall be reimbursed only for services performed by those physicians shown on Program records.

b. Periodically staff of the Medicaid Program shall survey hospitals for professional component billings. If the Medicaid Program has been billed and has paid for a physician service and if the recipient was not seen directly by the physician, a total refund shall be requested.

G. Hospital Component

1. The Medicaid Program shall reimburse the hospital at an approved prospective rate for days and services covered by the Program. The hospital shall bill the recipient ONLY for services and days NOT payable by the Medicaid Program. All monies paid except patient payments for non-covered items, by sources other than the Medicaid Program shall be entered in the space provided on the UB-82. Any amounts reported in excess of the noncovered services or days shall serve to reduce the Medicaid Program payment.

2. It shall be the hospital's responsibility to obtain permission for release of information from the recipient upon admission to the hospital. This release of information will enable an authorized representative of the Department for Medicaid Services to have access to the recipient's medical record, if necessary.

H. Payment From Recipient

The Medicaid Program requires all hospitals that participate in the Program to report ALL payments or deposits made toward a recipient's account, regardless of the source of payment. In the event that the hospital receives payment from an eligible Medicaid Program recipient for a covered service, the Medicaid Program regulations preclude payment being made by the Program for that service unless documentation is received that the payment has been refunded. This policy does not apply to payments made by recipients for spend-down or non-covered services.

All items or services considered by the Medicaid Program to be non-covered which were provided to Medicaid recipients during any period of a covered service can be billed to the recipient or any other responsible party. The amounts covering these items shall not be listed on the UB-82 as an amount received from other sources.

I. Equal Charge

The charge made to shall be the same charge made for comparable services provided to any party or payor.

J. Duplication of Payment

A covered service shall be reimbursed only one time. Any duplication of payment by the Medicaid Program whether due to erroneous billing or payment system faults, shall be refunded to the Medicaid Program. The address is listed in Section VI-A, Item #E.

Failure to refund a duplicate or inappropriate payment shall be interpreted as fraud and abuse, and prosecuted as such.

K. Hospice Benefits

If a recipient is receiving benefits under the Kentucky Medicaid Hospice Program, payment for hospital services (inpatient or outpatient) related to the recipient's terminal illness shall be billed by the hospice agency. If the inpatient or outpatient service is NOT related to the terminal illness, the hospice agency shall submit to the hospital an Other Hospitalization Statement (form MAP-383) and the hospital shall bill the Medicaid Program for these services utilizing the UB-82 billing form and and attaching a copy of the MAP-383. Without the MAP-383 attached, these services shall be rejected by the Medicaid Program.

L. Days

1. For Medicaid purposes, a day is considered in relation to the midnight census.

2. Medicaid shall pay the date of admission but shall not pay the date of discharge (death); however, all covered ancillary charges incurred on the date of discharge (death) shall be be Medicaid allowable covered charges.

3. Recipients or others shall not be billed for the date of discharge (death).

M. Reimbursement to Out-of-State Facilities

1. Inpatient Services

Effective for services provided on or after July 1, 1988, to June 30, 1990, reimbursement for out-of-state hospital inpatient services shall be seventy-five percent (75%) of usual and customary charges. Inpatient professional component services shall be reimbursed at one hundred percent (100%) of usual and customary charges.

Effective for services provided on or after July 1, 1990, reimbursement for out-of-state hospital inpatient services shall be the lower of seventy-five percent (75%) of usual and customary charges or the maximum in accordance with the per diem amount for a Kentucky hospital of comparable bed size plus 100% of professional component charges.

Effective for services provided February 1, 1991, all inpatient professional component services shall be reimbursed at seventy-five percent (75%) of the usual and customary charges.

2. Disproportionate Share Hospital Inpatient Services

Effective for services provided July 1, 1989 to June 30, 1990, inpatient services provided to recipients under age one (1) in those hospitals designated by Kentucky Medicaid as disproportionate share hospitals shall be reimbursed at eighty-five percent (85%) of covered charges plus 100% of usual and customary professional component charges.

Effective July 1, 1990, inpatient services provided to recipients under age one (1), for days of stay which for newborns are after thirty (30) days beyond the date of discharge for the mother of the child and for all other infants are thirty (30) days from the date of admission, in those hospitals designated by Kentucky Medicaid as disproportionate share hospitals shall be reimbursed at eight-five percent (85%) of the usual and customary actual billed charged up to one hundred ten percent (110%) of the per diem upper limit for the in-state peer group for comparably sized hospitals plus one hundred percent (100%) of professional component charges.

Effective for services provided on or after July 1, 1991, for out-of-state disproportionate share hospitals, an add-on fee equal to $1.00 as an addition to a hospital payment rate computed using appropriate upper limits (i.e., the in-state median cost per diem for the appropriate peer group); and for out-of-state hospitals with Medicaid utilization in excess of one (1) standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, a further payment adjustment which is equal to ten (10) cents for each one (1) percent of Medicaid utilization in the hospital which is in excess of utilization at the one (1) standard deviation level. This add-on amount shall be applicable to all recipients, not just recipients under age six (6) in disproportionate share hospitals and shall begin on the first day of the hospital stay and not on the thirty-first 31st day like other disproportionate share claims.

Effective February 1, 1991, all inpatient professional component services shall be reimbursed at seventy-five percent (75%) of the usual and customary charge.

3. Outpatient Services

Effective July 1, 1988, hospital outpatient services are reimbursed at sixty-five percent (65%) of usual and customary charges. Hospital outpatient professional component services shall be reimbursed at sixty-five percent (65%) of usual and customary charge. Professional component charges for emergency room physician services provided prior to July 1, 1990 are limited to a maximum payment of $35.00. Effective for services provided on or after July 1, 1990, the maximum of $35.00 was removed and emergency room physician services shall be reimbursed at sixty-five percent (65%) of the usual and customary charge.

Reimbursement for outpatient and nonpatient laboratory procedures will be in accordance with the latest available Title XVIII (Medicare) fee schedule.

SECTION VI - REIMBURSEMENT IN RELATION TO MEDICARE

VI. REIMBURSEMENT IN RELATION TO MEDICARE

A. Deductible and Coinsurance for Hospital Services

1. The Medicaid Program recipients who are also eligible for inpatient-outpatient hospital or physician benefits under Title XVIII-Parts A and B (Hospital Insurance-and Supplementary Medical Insurance) shall be required to utilize their benefits under Title XVIII prior to the availability of inpatient-outpatient hospital and physician benefits under the Medicaid Program.

   The Medicaid Program shall make payments on behalf of those Title XIX recipients who are also entitled to benefits under Title XVIII-Part A of Public Law 89-97. The Medicaid Program shall pay the in-hospital deductible, blood deductible, or coinsurance amounts as determined by Medicare. The coinsurance amount for the 61st - 90th day is 1/4 of the applicable deductible amount, and for the 91st - 150th Life Time Reserve Days it is 1/2 the applicable deductible amount.

   Section 301 of the Medicare Catastrophic Coverage Act of 1988 (MCCA) requires states to provide Medicaid coverage to certain Medicare beneficiaries in order to pay Medicare cost-sharing expenses (premium, deductible and coinsurance amounts). Individuals who are entitled to Medicare Part A and who do not exceed federally-established income and resources standards shall be known as Qualified Medicare Beneficiaries (QMB's).

   The Technical and Miscellaneous Revenue Act of 1988 (TAMRA) further provides that some individuals will have dual eligibility for QMB benefits and regular Medicaid benefits.

   When requesting payment for deductible or coinsurance days due under Title XVIII-Part A for inpatient services provided to Program recipients, the Medicare Check Remittance Advice or Medicare EOMB shall be attached to the UB-82.

2. The Medicaid Program shall make payment of the inpatient deductible' or coinsurance for those days the recipient is Medicaid or QMB eligible. Whether the Medicaid Program makes payment at the hospital's Title XIX prospective rate, or payment of deductible and coinsurance, or a combination of the two, shall depend upon the extent of the recipient's unused Title XVIII-Part A benefits. Computation and payment of the deductible or coinsurance shall be made by the Medicaid Program in accordance with the usual Program computation procedures.

   If the recipient has utilized his or her 90 benefit days and his or her 60 day "lifetime reserve" under Title XVIII - Part A, but has not begun a new spell of illness as defined under Title XVIII when readmission becomes necessary, the Medicaid Program shall make payment at the hospital's Title XIX prospective rate for up to 14 days, if PRO certification is obtained.

   If the recipient chooses not to utilize their Life Reserve Days under Title XVIII-Part A, the Medicaid Program shall not make payment as all Medicare benefits were not exhausted. Payment for services shall then remain the recipient's responsibility.

3. The Medicaid Program shall make payment of the recipient's blood deductible. There is no maximum on the amount per unit; however, Title XIX reimbursement is limited to three (3) units. Medicare, Title XVIII, shall be responsible for all remaining units used.

4. The Medicaid Program shall pay Part B deductible and coinsurance for hospital services (including the blood deductible) for recipients, in accordance with the Medicaid Program benefits, policies and procedures.

NOTE: As a result of the Medicare Catastrophic Coverage Act of 1988 (MCCA), effective February 1, 1989, the Medicaid Program shall provide reimbursement for all Medicare deductible and coinsurance amounts for those individuals who are concurrently Medicare beneficiaries and Medicaid recipients. Reimbursable services shall be limited to coinsurance and deductibles for all Medicare (Parts A and B) covered services or items regardless of whether the services or items are covered by Kentucky Medicaid.

B. Physician Services by Hospital-Based Physicians

Under the Medicaid Program, hospital-based physicians are defined in the same manner as in PRINCIPLES OF REIMBURSEMENT FOR SERVICES BY HOSPITAL-BASED PHYSICIANS (HIM-6).

The Medicaid Program shall pay Part B deductible and coinsurance for professional component in accordance with Program policies, procedures and benefits.

c. Primary Liability

When a recipient is receiving benefits from Title XVIII and Title XIX, Title XVIII accepts primary liability for all payment sought.

SECTION VI-A REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

VI-A. REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

A. General

To expedite the Medicaid claims processing payment function, the provider of Medicaid services shall actively participate in the identification of third party resources for payment on behalf of the recipient. At the time the providers obtain Medicaid billing information from the recipient, they shall determine if additional resources exist. Providers have an obligation to investigate and to report the existence of other insurance or liability by completing the TPL Lead Form and forwarding it to:

EDS
P.O. Box 2009
Frankfort, KY 40602
Attention: TPL Unit

The provider's cooperation will enable the Kentucky Medicaid Program to function more efficiently. Medicaid is the payor of last resort.

B. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medicaid Program, all participating providers shall submit billings for medical services to a third party when the provider has prior knowledge that the party may be liable for payment of the services.

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider shall inquire if the recipient meets any of the following conditions: Is the recipient married or working? If so, inquire about possible health insurance through the recipient's or spouse's employer. If the recipient is a minor, ask about insurance the MOTHER, FATHER, OR GUARDIAN may carry on the recipient. In cases of active or retired military personnel, request information about CHAMPUS coverage and social security number of the policy holder. For people over 65 or disabled, seek a MEDICARE number. Ask if the

recipient has health insurance such as a MEDICARE SUPPLEMENT policy, CANCER, ACCIDENT, OR INDEMNITY policy, GROUP health or INDIVIDUAL insurance, etc.

Examine the recipient's MAID card for an insurance code. If a code indicates insurance coverage, question the recipient further regarding the insurance.

Following is a list of the insurance codes on the MAID card:

A - Part A, Medicare only
Part B, Medicare only
C"- Both Parts A and B Medicare
D - Blue Cross/Blue Shield
E - Blue Cross/Blue Shield/Major Medical
F - Private medical insurance
G - Champus
H - Health Maintenance Organization
J - Unknown
K - Other
Absent Parent's insurance
; - None
N - United Mine Workers
P - Black Lung
Part A, Medicare Premium Paid
! - Both Parts A and B Medicare Premium Paid

C. Private Insurance

If the recipient has third party resources, then the provider shall obtain payment or rejection from the third party before Medicaid can be billed. When payment is received, the provider shall indicate on the claim form in the appropriate field the amount of the third party payment and the name and policy number(s) of health insurance covering the recipient. If the third party rejected the claim, a copy of the rejection notice shall be attached to the Medicaid claim. This rejection notice shall consist of recipient's name, date of service, termination or effective date of coverage, statement of benefits available (if applicable) and signature of the insurance representative or the letter shall be on the insurance company's letterhead.

SECTION VI-A REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

The insurance company remittance statement can be used to verify coverage. It shall consist of recipient name, dates of service, indication of denial or that the billed amount was applied to the deductible.

NOTE: Denials from insurance carriers stating additional information is necessary to process claims shall not be acceptable as verification of coverage.

Exceptions:

*If the other insurance company, including CHAMPUS, has not responded within 120 days of the date a claim is submitted to the insurance company, submit with the Medicaid claim a copy of the completed TPL Form and indicate "NO RESPONSE IN 120 DAYS" on the form. The Medicaid claim form and thecompleted TPL Lead Form shall be submitted to:

EDS
P.O. Box 2009
Frankfort, KY 40602
Attn: TPL Unit

*If proof of denial for the same recipient for the same or related services from the insurance company is attached to the Medicaid billing, claims processing can proceed. The denial cannot be more than six months old.

*A letter from the provider indicating that XYZ insurance company has been contacted and an agent verified that the recipient was not covered, can also be attached to the Medicaid claim. The letter shall include the name of the insurance company, address, phone number and the agent's name and telephone number (or notation indicating a voice automated response system was reached) as well as the recipient's name, MAID number and dates of service in question, the termination or effective date of coverage and statement of benefits available (if applicable).

SECTION VI-A REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

D. Medicaid Payment for Claims Involving a Third Party

If you have questions regarding third party payors, please contact:

EDS
Third Party Unit
P.O. Box 2009
Frankfort, KY 40602

(800) 756-7557
or
(502) 227-2525

Claims meeting the requirements for the Medicaid Program payment will be paid in the following manner if a third party payment is identified on the claim.

The amount paid by the third party shall be applied to any non-covered days or services and any remaining monies shall reduce the Medicaid Program payment. If the third party payment exceeds the Medicaid allowed amount, the resulting Medicaid Program payment shall be zero. Recipients cannot be billed for any difference in covered charges and the Medicaid payment amount. All providers have the choice in determining if this type of service shall be billed to the Kentucky Medicaid Program; however, if the Medicaid Program is billed for the service, then Program guidelines shall be followed. As a result, providers shall accept Medicaid payment as payment in full.

Detailed below are sample Medicaid payment methodologies for in-state and out-of-state inpatient hospital services. These payment formulas can be used to determine the amount due on any inpatient admission which is greater than fourteen days with third party involvement.

EXAMPLE 1 - Pricing example for in-state hospitals using a per diem rate:

Step 1:	$ 470.33	Medicaid Per Diem Rate
	x 14	Days Payable
	$6,584.62	Medicaid Maximum Payment
Step 2:	$36,592.11	Total charges for 24 day stay (entire stay)
	-25,150.67	Billed charges for covered period
	$11,441.44	TPL Balance
	-11,913.10	Amount received from other source
	$ -471.66	TPL balance. If this amount is negative, Medicaid payment is reduced. If the amount is positive, Medicaid payment is not reduced
Step 3:	$6,584.62	Amount payable
	- 471.66	TPL Balance
	$ 6,112.96	Amount due from the Medicaid Program

EXAMPLE 2 - Pricing example for out-of-state hospitals using percentage of charges:

Step 1:	$20,550.00	Billed charges for 14 day covered period
	200.00	Non-covered charges
	$20,350.00	Covered charges for days payable
	x 75%	Reimbursement rate
	$15,262.50	Medicaid maximum payment
Step 2:	$36,000.00	Total charges for total stay (20 days)
	-20,550.00	Total charges for covered stay
	$15,450.00	
	-19,000.00	Amount received from other sources
	$-3,550.00	TPL Balance. If this amount is negative, Medicaid payment is reduced. If the amount is positive, Medicaid payment is not reduced

Step 3:
$15,262.50 Medicaid maximum payment
-3,550.00 TPL balance
$11,712.50 Amount due from Medicaid if paid using percentage as rate.

Step 4: The computed payment is compared against the maximum rate for in-state hospitals of comparable bed size using payment formula for instate hospitals. Final Medicaid payment will be the lower of the two formulas

NOTE: If there is no third party involvement only Step 1 is necessary under either payment formula.

If the claims for a recipient are payable by a third party resource which was not pursued by the provider, the claim shall be denied. Along with a third party insurance denial explanation, the name and address of the insurance company, the name of the policy holder, and the policy number will be indicated on the remittance statement. The provider shall pursue payment with this third party resource before billing Medicaid again. Itemized statements shall be stamped "Medicaid Assigned" when they are forwarded to insurance companies, attorneys, recipients, etc.

E. Amounts Collected from Other Sources

1. If subsequent to billing the Medicaid Program, a provider receives monies for a service which, when added to the Medicaid Program's and all other payments for the service, creates an excess over the defined maximums then that excess amount shall be refunded to the Medicaid Program up to the total amount paid by the Medicaid Program. Refund checks shall be made payable to the "Kentucky State Treasurer" and mailed directly to: EOS, P.O. Box 2009, Frankfort, KY 40602, Attn: Cash and Finance Unit.

2. When verification exists that the recipient has received monies from a liable third party for services paid by the Medicaid Program, the provider shall refund the full amount paid by the Medicaid Program and may seek total charges from the recipient. If the recipient did not receive enough monies to cover the total service, the provider may rebill the Medicaid Program, showing all amounts received from other sources.

3. As a result of the passage of recent legislation, any time a Medicaid recipient requests an itemized bill and the Medicaid Program has made payment or has been billed for payment, the hospital shall release the bill. Each page shall be stamped indicating that the bill is for informational purposes only. In addition, the hospital shall complete the TPL Lead Form and forward it to EDS.

4. Please refer to the reverse side of the recipient's Medical Assistance Identification Card for the recipient's assignment of benefits: "You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf."

F. Accident and Work Related Claims

For claims billed to the Medicaid Program that are related to an accident or work related incident, the provider shall pursue information relating to the accident. If an employer, individual or an insurance carrier is a liable party, but the liability has not been determined, you shall proceed with submitting your claim to EDS if you provideany information obtained, such as the names of attorneys, other involved parties and or the recipient's employer.

EDS
P. 0. Box 2009
Frankfort, KY 40602
Attention: TPL Unit

VII. COMPLETION OF INVOICE FORM

A. General

The UB-82 invoice shall be used to bill for services provided in an acute care hospital to eligible Medicaid recipients. Typing of the invoice form is strongly urged, since an invoice cannot be processed unless the information supplied is complete and legible.

The original of the UB-82 shall be submitted to EDS as soon as possible after services are provided. A copy shall be retained by the provider.

All UB-82 invoices shall be sent to:

EDS
P.O. Box 2045
Frankfort, KY 40602

Under Federal Regulation (42 CFR 447.45) effective August 23, 1979, a requirement relating to timely submission of claims under Title XIX was added. Providers shall submit claims within twelve (12) months of the date of service.

It is extremely important that the ancillary services reported on the UB-82 billing form be submitted by using the correct Revenue Codes. All approved Revenue Codes are listed in Appendix XIX. Incorrect billing of ancillary services or failure to correct any errors may ultimately affect of the instate provider's prospective payment rate.

If the admission involves a payment from a third party payor, an itemized or summarized bill shall be attached to each UB-82 for admissions which contain non-covered days.

IMPORTANT: The recipient's Kentucky Medical Assistance Identification Card should be carefully checked to see that the recipient's name appears on the card as an eligible recipient and that the card is valid for the period of time in which the

medical services are to be provided. Services provided to an ineligible person are not reimbursable.

B. Electronic Media Claims (EMC)

Acute care hospitals are now allowed to submit regular claims via electronic media. Providers shall continue using paper claims for all crossover services or any claim which requires attachments. For detailed information regarding EMC billing, contact: EDS, P.O. Box 2009, Frankfort, Kentucky-40602 or call 1-(800)- 756-7557 or (502) 227-2525.

c. Medicare Deductibles and Coinsurance

Billing for Medicare Part A deductible or coinsurance days, Medicare Part B deductible or coinsurance and Title XIX services shall be on separate claim forms. Example: If the recipient was covered by Medicare Part A, Medicare Part B and Medicaid, three separate claims shall be submitted for payment of the three types of benefits. A Medicare Explanation of Benefits or Remittance Advice shall be attached to EACH UB-82.

Medicaid PRO certification is not required on Medicare deductible and coinsurance claims as certification was determined using Medicare guidelines. If all Medicare benefits are exhausted and Title XIX days are being billed, then Medicaid PRO certification for those Medicaid days shall be necessary.

Effective for claims processed on and after October 12, 1991, the Medicare Division of Blue Cross/Blue Shield, Louisville, Kentucky began transmitting Medicare Part A and B claims directly to the Medicaid Program via tape. If a claim does not appear on the Medicaid Remittance Statement within thirty (30) days of the Medicare adjudication date, a paper UB-82 with the corresponding Medicare Remittance Advice shall be submitted to the Medicaid Program.

Effective for claims processed on and after September 13, 1991, the Medicare Division of Blue Cross/Blue Shield, Lexington, Kentucky began transmitting Medicare Part B claims covering hospital-based physicians (i.e., emergency room physician, anesthesiologist, cardiologist, etc.) directly to the Medicaid Program.via tape. If a claim does not appear on the Medicaid Remittance Statement within thirty (30) days of the Medicare adjudication date, a paper HCFA-1500 (Rev. 12\90) with the corresponding Medicare Explanation of Benefits shall be submitted to the Kentucky Medicaid Program for processing in accordance with billing instructions contained in Section VII, G.

Providers utilizing a Medicare fiscal intermediary other than those listed above shall continue to submit all Medicare Cross-over claims using paper UB-82s or HCFA-1500s with the corresponding Medicare Remittance Advice or EOMB to each claim.

D. Unassigned Medicare/Medicaid Claims

If Medicaid is to be billed for Medicare deductible or co-insurance amounts for Medicare Part A or Part B services provided on and after April 1, 1990, the provider of services shall accept assignment. Unassigned claims shall be denied by Kentucky Medicaid.

The Medicaid Program shall not make payment on an unassigned claim for services provided prior to April 1, 1990 unless the claim was filed with Medicare without knowledge by the provider of the recipient's eligibility for Medicaid or QMB benefits.

Theseclaims can be processed as follows:

1. The Medicare amount paid shall be refunded to Medicare and any payment made by the recipient shall be refunded to the recipient

or

2. The hospital can submit to EDS the Explanation of Medicare Benefits (EOMB), the UB-82, and a letter signed by the authorized representative of the hospital stating the following:

   a. The recipient had paid the hospital only the amount allowed by Medicare minus any deductible and coinsurance amounts. If the recipient has paid the deductible or coinsurance' amounts or both, that payment shall be refunded to the recipient prior to billing Kentucky Medicaid.

   b. The amount paid by the recipient and by Medicaid shall be considered payment in full.

   c. The hospital did not have knowledge of the recipient's Medicaid eligibility at the time the Medicare claim was filed.

   BY submitting the letter, the hospital accepts assignment.

E. Outpatient Services Provided Prior to Admission as Inpatient

Effective for services provided on and after June 1, 1991, the Kentucky Medicaid Program requires that all outpatient services provided prior to the actual admission as an inpatient be submitted on a separate billing claim from the claim for inpatient services. This policy change has created problems involving Medicaid recipients who have only Part B of Medicare because this billing procedure is not utilized by Medicare. Medicare requires all charges, both inpatient and outpatient,

be submitted on one claim as an inpatient service. As a result, the provider and the beneficiary\recipient are left with charges being denied by both Medicare and Medicaid.

Inorder to eliminate this problem, the Program has implemented Type of Bill 134 along with special system edits that will identify these cases and permit them to be processed. Your facility should utilize this Type of Bill (TOB) when you encounter charges (i.e., emergency room, drugs, supplies, etc.) for services that are being denied because Medicare considers them to be inpatient services, the individual does not have Medicare Part A coverage but is eligible for Kentucky Medicaid benefits. Type of Bill 134 is effective for services provided on and after June 1, 1991.

In addition, the facility shall enter the phrase "outpatient charges not covered by Medicare" in Form Locator #94 on the UB-82 billing form when claims are submitted to the Kentucky Medicaid Program for payment. This notation will help identify the reason the services were submitted without the usual Medicare Remittance Advice.

F. UB-82 Billing Instructions

Following are form-locator by form-locator instructions for billing Medicaid Services on the UB-82 billing statement. Only instructions for form locators required for EDS processing or the Medicaid Program information are included. Instructions for form locators not used by EDS or the Medicaid Program processing can be found in the UB-82 Training Manual. The UB-82 Training Manual may be obtained from the Kentucky Hospital Association, P.O. Box 24163, Louisville, Kentucky 40224. You may also obtain the UB-82 billing forms from the above address.

F.L.1 PROVIDER NAME, ADDRESS AND TELEPHONE

Enter the complete name and address of the facility. The telephone number, including area code, is desired.

SECTION VII - COMPLETION OF INVOICE FORM

F.L.3 PATIENT CONTROL NUMBER

Enter the patient control number (must be numeric) assigned by the facility. The first seven digits will appear on the Remittance Statement.

F.L.4 TYPE OF BILL

Enter the appropriate 3-digit code to indicate the type of bill.

1st Digit (Type of facility)	1 = Hospital
2nd Digit (Bill Classification	1 = Inpatient (including Medicare Part A) 2 = Inpatient (Medicare Part B only) 3 = Outpatient 4 = Non-patient
3rd Digit (Frequency)	0 = Non-payment 1 = Admit through Discharge 2 = Interim, first claim 3 = Interim, continuing claim 4 Interim, final claim

NOTE: The 3rd digit for regular Medicaid outpatient services will always be a 1.

TOB 134 has been established and shall be used to accomodate services (i.e., emergency room, observation room, etc.) provided to recipients with only Part B of Medicare coverage that were admitted as an inpatient through the outpatient department. Please refer to Section VII, item #E for further instruction.

SECTION VII - COMPLETION OF INVOICE FORM

F.L.8 MEDICAID PROVIDER NUMBER

Enter the assigned 8-digit KENTUCKY Medicaid provider number.

F.L.15 ADMISSION DATE

Enter the date of actual admission to the facility in month, day, year numeric format.

F.L.16 ADMISSION HOUR

Enter the code for the time of admission to the facility, BOTH INPATIENT AND OUTPATIENT.

CODE STRUCTURE

CODE	TIME A.M.	CODE	TIME P.M.
00	12:oo - 12:59 midnight	12	12:oo - 12:59 noon
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	lo:oo - 10:59	22	lo:oo - 10:59
11	ll:oo - 11:59	23	ll:oo - 11:59

SECTION VII - COMPLETION OF INVOICE FORM

F.L.17 TYPE OF ADMISSION (Inpatient only)

Enter the appropriate code for type of inpatient admission.

1 = Emergency
2 = Urgent
3 = Elective
4 = Newborn

F.L.21 PATIENT STATUS (Inpatient only)

Enter the appropriate 2 digit patient status code indicating patient disposition at the time of the billing for the given period of care. Refer to the UB-82 Training Manual for detailed codes and explanations.

F.L. 22 STATEMENT COVERS PERIOD

The Medicaid Program shall reimburse the facility up to the maximum of fourteen (14) COVERED days per admission.

EXCEPTIONS: Hospitals designated by Kentucky Medicaid as disproportionate share hospitals are not limited to the 14 day maximum when billing for services provided to recipients under age six (6). In these cases, days are unlimited, however, each calendar month of service shall be billed on separate billing forms.

Medicare and Medicaid crossover services are not limited to the 14 day maximum. Enter the actual COVERED dates of service as the FROM and THROUGH dates.

The "FROM" date is the date of the admission, if the recipient was eligible for the Medicaid Program benefits on admission. If the recipient was not eligible on the date of the admission, the "FROM" date is the effective date of eligibility.

SECTION VII - COMPLETION OF INVOICE FORM

For final bills, the "THROUGH" date is the fourteenth (14th) day, or last day of stay.

Enter both "FROM" and "THROUGH" dates in MM-DO-YY format.

All regular outpatient services shall be billed utilizing the actual date of service. Recurring outpatient services (i.e., physical therapy, laboratory services, etc.) shall be billed as calendar month pure claims.

F.L.23 COVERED DAYS (Inpatient Only)

Enter the total number of COVERED days from form locator 22. Data entered in form locator 23 must agree with accommodation units in form locator 52.

F.L.24 NONCOVERED DAYS (Inpatient, Only)

Enter the number of days of care not covered by the Medicaid Program.

F.L.25 CO-INSURANCE DAYS (Medicare Crossover Claims)

Enter the number of coinsurance days billed to the Medicaid Program during this billing period. Attach Medicare documentation.

F.L.26 LIFETIME RESERVE DAYS (Medicare Crossover Claims)

Enter the Lifetime Reserve days the patient has elected to use for this billing period. Attach Medicare documentation.

F.L.28 OCCURRENCE CODES AND DATES

Enter the code(s) and associated date(s) defining a significant event(s) relating to this bill. Refer to UB-82 Training Manual for codes and explanations.

SECTION VII - COMPLETION OF INVOICE FORM

F.L.40 PINTS OF BLOOD FURNISHED

Enter the total number of pints of whole blood or units of packed red cells furnished to the recipient.

F.L.41 PINTS OF BLOOD REPLACED

Enter the total number of pints of blood or units of packed red cells furnished to the recipient that have been replaced by or on behalf of the recipient.

F.L.42 PINTS OF BLOOD NOT REPLACED

Enter the total number of pints of blood or units of packed red cells that have not been replaced by or on behalf of the recipient.

F.L.43 BLOOD DEDUCTIBLE (Medicare Crossover Claims)

Enter the total number of unreplaced pints of blood or units of packed red cells furnished to the recipient that have been replaced by or on behalf of the recipient.

F.L.44 SPECIAL PROGRAM INDICATOR

Enter the code indicating that the services included on this bill are related to a special program. Refer to the UB-82 Training Manual for detailed codes and explanations.

F.L.45 KENPAC PROVIDER NUMBER (KenPAC Recipients Only)

Enter the B-digit Kentucky Medicaid provider number of the recipient's KenPAC Primary Physician or Clinic on the upper line in this area.

SECTION VII - COMPLETION OF INVOICE FORM

F.L.50 REVENUE DESCRIPTION

Enter the narrative description of the related room, board and ancillary categories included on the bill. Enter the appropriate CPT-4 codes for outpatient or non-patient laboratory services for Revenue Codes 30X and 31X.

NOTE:

CLAIMS WITH A DATE OF SERVICE PRIOR TO DECEMBER 1, 1987, REQUIRE 1985 CPT-4 CODES

CLAIMS WITH A DATE OF SERVICE ON OR AFTER DECEMBER 1, 1987, THROUGH APRIL 30, 1988, REQUIRE 1987 CPT-4 CODES

CLAIMS WITH A DATE OF SERVICE ON OR AFTER MAY 1, 1988 THROUGH MARCH 31, 1989, REQUIRE 1988 CPT-4 CODES

CLAIMS WITH A DATE OF SERVICE ON OR AFTER APRIL 1, 1989 THROUGH MARCH 31, 1990, REQUIRE 1989 CPT-4 CODES

CLAIMS WITH A DATE OF SERVICE ON OR AFTER APRIL 1, 1990, THROUGH MARCH 31, 1991, REQUIRE 1990 CPT-4 CODES.

CLAIMS WITH A DATE OF SERVICE ON OR AFTER APRIL 1, 1991, THROUGH JANUARY 14, 1992, REQUIRE 1991 CPT-4 CODES

CLAIMS WITH A DATE OF SERVICE ON OR AFTER JANUARY 15, 1992 REQUIRE 1992 CPT-4 CODES.

F.L.51 REVENUE CODES

Enter the 3-digit code identifying specific accommodation and ancillary services. A list of the Revenue codes accepted by Kentucky Medicaid can be found in Appendix XIX.

NOTE: Revenue code 001 shall always be the final entry in this column.

SECTION VII - COMPLETION OF INVOICE FORM

F. L.52 UNITS OF SERVICE

Enter the quantitative measure of services provided per revenue code to the recipient to include such items as numbers of accommodation days, pints of blood, treatments, etc.

F.L.53 TOTAL CHARGES

Enter the total charges pertaining to the related Revenue codes for the billing period.

The detailed amounts, by Revenue codes, shall equal the entry "Total Charges."

F.L.54 NON-COVERED CHARGES

Enter the charges from form locator 53 that are non-payable items by Kentucky Medicaid.

*Form locators 57-70 are divided into 3 lines to *
accommodate the primary, secondary, and tertiary payers
*Payment information shall be indicated on the *
*corresponding line of the appropriate payer in the *
*correct form locators 57-64. Enter the Insured's Name *
*in form locator 65 A, B, and C, respectively *

F.L.57 PAYER IDENTIFICATION

Enter the name of payer organization from which the provider expects payment.

All other liable payers, including Medicare, shall be billed first; after settlement has been made with these payers, Medicaid can be billed for any payable balance. The Medicaid Program is payer of last resort and shall be identified as Kentucky Medicaid or KY Medicaid.

SECTION VII - COMPLETION OF INVOICE FORM

F.L.60 DEDUCTIBLE (Medicare Crossover Claims)

Enter the amount as shown on the Medicare EOMB to be applied to the recipient's deductible amount due. Attach Medicare documentation.

F.L.61 CO-INSURANCE (Medicare Crossover Claims)

Enter the amount as shown on the Medicare EOMB to be applied toward the recipient's coinsurance amount due. Attach Medicare documentation.

F.L.63 PRIOR PAYMENTS

Enter the amount the facility has received toward payment of the account prior to the billing date. Spend-down amount and third party payment shall be entered in this area.

NOTE: Effective for claims from Kentucky hospitals RECEIVED MARCH 1, 1987, and after, do not enter the inpatient charges being billed to Medicare Part B in Form Locator #63 of the UB-82 claim form, type of bill **111.** This does not apply to out-of-state hospitals which participate in the Medicaid Program.

F.L.65 INSURED'S NAME

Enter the recipient's name in last name and first name sequence as it appears on his or her current Medical Assistance Identification Card.

F.L.68 IDENTIFICATION NUMBER

Enter the 10 digit MAID number as it appears on his or her current Medical Assistance Identification Card.

SECTION VII - COMPLETION OF INVOICE FORM

F.L.77 PRINCIPAL DIAGNOSIS CODE

Enter the ICD-9-CM, Vol. 1 & 2 code describing the principal diagnosis at the time of admission.

F.L.7881 OTHER DIAGNOSIS CODES

Enter the ICD-9-CM, Vol. 1 & 2 diagnosis codes corresponding to additional conditions that co-exist at the time of admission.

F.L.84 PRINCIPAL PROCEDURE CODE

Enter the ICD-9-CM (Vol. 3) code that identifies the principal obstetrical or surgical procedure performed during the period covered by the bill and the date on which-the procedure was performed.

F.L.85 OTHER PROCEDURES CODE(S) AND DATE(S)

Enter the codes identifying the procedures, other than the principal procedure, performed during the billing period covered by this bill and the date on which the procedures were performed.

SECTION VII - COMPLETION OF INVOICE FORM

F.L.87 PRO/UR INDICATOR

Enter the indicator describing the determination arrived at by the PRO/Utilization Review Committee.

Indicator 1 = Approved as Billed
2 = Automatic Approval as Billed Based on Focus Review
3 = Partial Approval*

*If PRO/UR grants partial approval for a portion of the recipient's hospital stay, the approved dates shall be indicated in form locators 88 and 89. These dates shall agree with the dates in form locator 22.

F.L.92 ATTENDING PHYSICIAN

Enter the six-digit Unique Physician Identification Number (UPIN) and name of the attending physician.

F.L.93 OTHER PHYSICIAN ID

Enter the name and license number of physician other than attending physician.

F.L.95 PROVIDER REPRESENTATIVE SIGNATURE

The actual signature of the provider's authorized representative is required. Stamped signatures are not accepted.

F.L.96 DATE BILL SUBMITTED

Enter the date in month, day, year sequence in numeric format that the UB-82 form was completed and signed.

SECTION VII - COMPLETION OF INVOICE FORM

UB-82 BILLING INSTRUCTIONS

Disproportionate Share Hospitals Covering Services Provided
July 1, 1989 through June 30, 1990

1. Charges for newborns shall be submitted under the mother's name and Medical Assistance identification number (MAID#) until the date of the mother's discharae. The mother's date of discharge is the "From" date in Form locator 22 on the initial claim for the infant.

2. Only services provided during medically necessary admissions, as determined by the PRO, are billable. Out-of-state hospitals shall perform utilization review in accordance with standards set by their state's Medicaid agency.

3. Although the date of discharge and the first birthday are non-covered days, ancillary charges incurred on the date of discharge or first birthday are covered.

4. Claims for these services shall be calendar month pure, e.g. July 1, 1989 through July 31, 1989, August 1, 1989, through August 31, 1989.

5. All Kentucky Medicaid recipients are eligible for a maximum of fourteen (14) days of medically necessary inpatient hospital services per admission; therefore, when a recipient in a disproportionate share hospital reaches age one (1) and the CURRENT admission is less than fourteen (14) days in length, the balance of the admission (first birthday through the 14th day) shall be billed on a separate UB-82 claim form which will be reimbursed at the hospital's regular Medicaid per diem rate. Charges incurred on the first birthday must be included ONLY on the claim which will be reimbursed at the hospital's regular Kentucky Medicaid per diem rate.

6. When a recipient in a disproportionate share hospital reaches age one (1) and the CURRENT admission is equal to, or greater than, fourteen (14) days in length, the first birthday becomes the "THROUGH" date in Form Locator 22 and additional days cannot be billed to Medicaid for the admission.

SECTION VII - COMPLETION OF INVOICE FORM

BILLING EXAMPLES FOR DISPROPORTIONATE SHARE HOSPITALS
Services Provided July 1, 1989, through June 30, 1990

A. The infant's date of birth is 08/20/88; admitted to a disproportionate share hospital on 07/06/89, discharged 09/02/89, the billings would be as follows:

First Bill: DOA 07/06/89, TOB 112, Patient Status 30, Statement Covers Period 07/06/89-07/31/89, 26 covered days to be paid at the disproportionate share hospital rate.

Second Bill: DOA 07/06/89, TOB 114, Patient Status 01, Statement Covers Period 08/01/89-08/20/89, 19 covered days to be paid at at the disproportionate share hospital rate. Enter code 42 and 09/02/89 in form locator 28. The infant's first birthday is non-covered, and therefore considered the date of discharge for billing purposes.

B. The infant's date of birth is 08/20/88; admitted to a disproportionate share hospital on 08/10/89, discharged 09/02/90, and readmitted 09/29/89, the billings would be as follows:

First Bill: DOA 08/10/89, TOB 111, Patient Status 01, Statement Covers Period 08/10/89-08/20/89, 10 covered days to be paid at the disproportionate share hospital rate.

Second Bill: DOA 08/10/89, TOB 111, Patient Status 01, Statement Covers Period 08/20/89-08/24/89, 4 covered days to be paid at the regular hospital per diem. Enter code 42 and 09/02/89 in form locator 28 as the actual date of discharge.

Third Bill: DOA 09/29/89, TOB 111, Patient Status 01, Statement Covers Period 09/29/89-10/13/89, 14 covered days to be paid at the regular hospital per diem rate with appropriate justification attached to indicate reason for readmission within 30 days of previous discharge.

C. The infant's date of birth is 07/05/89, the mother is discharged from the hospital on 07/10/89, and the infant remains hospitalized until 12/20/89, the billings would be as follows:

First Bill: DOA 07/05/89, TOB 110, Patient Status 01, Statement Covers Period 07/05/89-07/10/89,5 covered days. This bill is submitted under the mother's MAID number. This bill is a zero payment bill for in-state hospitals. All out-of-state hospitals shall bill this service using TOB 111 because services are paid at a percentage of usual and customary charges without year-end cost adjustment.

Second Bill: DOA 07/05/89, TOB 112, Patient Status 30, Statement Covers Period 07/10/89-07/31/89, 22 covered days to be paid at the disproportionate share hospital rate.

Third Bill: DOA 07/05/89, TOB 113, Patient Status 30, Statement Covers Period 08/01/89-08/31/89, 31 covered days to be paid at disproportionate share hospital rate.

Interim billings shall be submitted until the infant is discharged from the facility or until the infant's first birthday. Bills shall be submitted for one calendar month per UB-82.

Final ć 11: DOA 07/05/89, TOB 114, Patient Status 01, Statement Covers Period 12/01/89-12/20/89, 19 covered days to be paid at disproportionate share hospital rate.

SECTION VII - COMPLETION OF INVOICE FORM

UB-82 Billing Instructions
Disproportionate Share Hospitals Covering Services Provided On and After July 1, 1990

1. Services provided July 1, 1990 through June 30, 1991, to recipients under age one in hospitals designated as disproportionate share hospitals by Kentucky Medicaid shall be reimbursed at the regular Medicaid rate for the first thirty (30) days of the admission. Beginning on the thirty-first (31st) day of the admission, the disproportionate share rate becomes effective.

2. For newborns, the date of admission is the date of the mother's discharge on all claims for services provided on and after the mother's discharge. Because the rate change is enacted in relation to the admission date, it is critical that the admission date be correct and constant on all claims.

3. Transfers between hospitals for individuals under age one (1) shall constitute new admissions and the receiving hospital shall receive its regular Kentucky Medicaid rate for the first thirty (30) days of the admission.

4. When Kentucky Medicaid payment for an admission will include the disproportionate rate, i.e. the admission surpasses thirty days, separate UB-82 claim forms must be submitted to coincide with the appropriate rates. In addition, you are reminded that these claims shall be calendar month pure.

5. Effective for services provided on and after July 1, 1991, by hospitals designated by the Kentucky Medicaid Program as disproportionate share hospitals, recipients under age six (6) are eligible for medically necessary inpatient services without durational limits, regardless of any prior utilization of hospital services.

6. Effective for services provided on and after July 1, 1991, the Kentucky Medicaid Program will provide reimbursement for medically necessary inpatient services, without durational limits, regardless of any prior utilization of hospital services, for recipients under age one (1). Reimbursement is available as described above irrespective of designation as a disproportionate share hospital.

SECTION VII - COMPLETION OF INVOICE FORM

BILLING EXAMPLES FOR DISPROPORTIONATE SHARE HOSPITALS
Services provided on and after July 1, 1990

A. An infant is born in a disproportionate share hospital on July 15, 1990, the mother is discharged on July 18, 1990, and the infant is discharged on October 13, 1990.

	STATEMENT COVERS PERIOD	TYPE OF BILL	NUMBER OF DAYS	RATE OF REIMBURSEMENT
Claim #1	07/15/90 to 07/18/90	110*	3	Zero Pay*
			14	Regular
Claim #3	08/01/90 to 08/16/90	112	16	Regular
Claim #4	08/17/90 to 08/31/90	113	15	Disproportionate Share
Claim #5	09/01/90 to 09/30/90	113	30	Disproportionate Share
Claim #6	10/01/90 to 10/13/90	114	12	Disproportionate Share

*Because Kentucky Medicaid does not cost settle with out-of-state hospitals, out-of-state disproportionate share hospitals shall continue to bill this claim as Type of Bill 111 and reimbursement will be the lower of the two methodologies.

B. The infant is born on July 10, 1990, is admitted to a disproportionate share hospital on August 2, 1990, becomes Kentucky Medicaid eligible on August 14, 1990, and is discharged on September 10, 1990.

	STATEMENT COVERS PERIOD OF PERIOD	TYPE OF BILL	NUMBER OF DAYS	RATE OF REIMBURSEMENT
Claim #1	08/14/90 09/01/90 to to 08/31/90 09/10/90	112 114	18 9	Disproportionate Regular
Claim #2				Share

SECTION VII - COMPLETION OF INVOICE FORM

G. HCFA-1500 (12/90) Billing Instructions

The Medicare Part B cross-over claims covering hospital-based physician services (i.e., emergency room physician, anesthesiologist, cardiologist, etc.) are transmitted to the Kentucky Medicaid Program by Blue Cross/Blue Shield, Lexington, Kentucky via tape. If a claim, covering the Part B deductible or coinsurance amount, does not appear on the Medicaid Remittance Statement within thirty (30) days of the Medicare adjudication date, a paper HCFA-1500 (Rev. 12/90) with the corresponding Explanation of Benefits shall be submitted to Kentucky Medicaid utilizing the billing instructions listed below.

Note: Only those fields required for billing Kentucky Medicaid are completed. Specific billing requirements are indicated within the claim form field description.

Field	Description
1	INSURANCE IDENTIFICATION INDICATOR Check the "Medicare" and "Medicaid" **blocks** when billing a claim to Medicare requesting Medicare to send the claim to Medicaid for processing coinsurance and deductible amounts.
1A	INSURED'S I.D. NUMBER Required only if billing Kentucky Medicaid for coinsurance and deductible (Medicare\Medicaid crossover claims). Enter the recipient's Medicare identification number.
	PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) Enter the recipient's last name, first name, middle initial exactly as it appears on the Medical Assistance Identification (MAID) Card.

SECTION VII - COMPLETION OF INVOICE FORM

9A OTHER INSURED'S POLICY OR GROUP NUMBER

Enter the recipient's ten-digit Medical Assistance Identification Number (MAID) exactly as it appears on the recipient's MAID card.

10 PATIENT'S CONDITION

Required if recipient's condition is related to employment, auto accident, or other accident. Check the appropriate "yes" block if recipient's condition relates to one of the above; otherwise, leave blank.

11 INSURED'S POLICY GROUP OR FECA NUMBER

Required if recipient has another insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim. Enter the policy number of the other insurance.

11C INSURANCE PLAN NAME OR PROGRAM NAME

Required if recipient has another insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim. Enter the name of the other insurance company.

17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

Complete if recipient was referred from another provider to the billing provider for consultation procedures. Enter the name of the referring provider, if applicable.

17a I.D. NUMBER OF REFERRING PHYSICIAN

Enter the six-digit Unique Physician Identification Number **(UPIN)** of the referring physician, if applicable.

19 RESERVED FOR LOCAL USE

Required for KenPac and Lock-In recipients who are referred for treatment. Enter the eight-digit Medicaid provider number of referring KenPac or Lock-In provider.

SECTION VII - COMPLETION OF INVOICE FORM

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

Enter the appropriate ICD-9-CM diagnosis code as the diagnosis code appears in the ICD-9-CM International Classification of Disease Book. You may enter up to three diagnosis codes.

24A DATE(S) OF SERVICE

Enter the date(s) the service was provided in month, day, year sequence and in numeric format; for example 03/02/92.

24B PLACE OF SERVICES

Enter the appropriate two-digit place of service code which identifies the location where the service was provided to the recipient. The correct code for inpatient hospital services is 21 and outpatient hospital services is 22.

24D PROCEDURES, SERVICES, OR SUPPLIES

CPT/HCPCS

Enter the appropriate procedure code identifying the service or supply provided to the recipient.

24E DIAGNOSIS CODE

Enter "1", "2", "3" referencing the diagnosis for which the recipient is being treated as indicated in field 21.

24F CHARGES

Enter the usual and customary charge for the service being provided to the recipient.

26 PATIENT'S ACCOUNT NO.

Enter the patient account number, if desired. EDS will key up to seven (7) alpha/numeric characters. This number appears on the Medicaid remittance statement as the invoice number.

SECTION VII - COMPLETION OF INVOICE FORM

28 TOTAL CHARGE

Enter the total of all individual charges entered in column 24F. Total each claim separately.

29 AMOUNT PAID

Enter the amount paid, if any, by a private insurance. DO NOT ENTER MEDICARE PAID AMOUNT.

30 BALANCE DUE

REQUIRED ONLY IF A PRIVATE INSURANCE MADE PAYMENT ON THE CLAIM. Subtract the private insurance payment entered in field 29 from the total charge entered in field 28, and enter the net balance due in field 30.

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

A handwritten signature is required. A delegated signature such as an authorized representative of the provider is acceptable. Stamped signatures, however, are not acceptable.

DATE

Enter the date in a month, day, year sequence and in numeric format. 'This date must be on or after the date(s) of service billed on the claim. For example, enter the date as 04/18/92.

33 PHYSICIAN'S SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE, AND PHONE NUMBER

Enter the provider's name, address, zip code and telephone number.

PIN#

Enter the eight-digit individual Kentucky Medicaid hospital provider number.

SECTION VIII - REMITTANCE STATEMENT

VIII. REMITTANCE STATEMENT

A. General

The EDS Remittance Statement furnishes the provider with an explanation of the status of those claims EDS processed. The Remittance Statement accompanies the payment check and is divided into six sections.

The first section provides an accounting of those claims which are being paid by the Medicaid Program with the accompanying payment check.

The second section provides a list of claims which have been rejected (denied) in total with the corresponding Explanation of Benefit (EOB) code.

The third section provides a list of claims EDS received which did not complete processing as of the date indicated on the Remittance Statement.

The fourth section provides a list of claims received by EDS that could not be processed as the result of incomplete claim information. These claims have been returned to the provider along with a cover letter that explains the reasons for the return.

The fifth section. includes the summation of claims payment activity as of the date indicated on the Remittance Statement and the year-to-date claims payment activities.

The sixth section provides a list of the EOB codes which appeared on the dated Remittance Statement with the corresponding written explanation of each EOB code.

Claims appearing in any section of the Remittance Statement will be in alphabetical order according to the patient's last name.

B. Medicare Deductibles and Coinsurance

The explanation of payment for any MEDICARE deductibles an coinsurance will appear on a separate page from regula Medicaid claims and in a slightly different format. Th provider shall bill the Medicare program for any Medicar covered services provided to recipients over 65 and othe eligible persons (the disabled and the blind). The Medicar Program does not cover the patient's deductible and coinsuranc amounts but the the Medicaid Program will make payment of thes amounts for Medicaid eligible recipients.

c. Section I - Claims Paid

Examples of the first section of the Remittance Statement ar shown in Appendix XVI. This section lists all of those claim for which payment is being made for inpatient and outpatien services. On the pages immediately following are item-by-ite explanations of each individual entry appearing in this sectio of the Remittance Statement.

EXPLANATION OF REMITTANCE STATEMENT FOR HOSPITAL SERVICES

ITEM	
INVOICE NUMBER	The preprinted invoice number (or patient account number) appearing on each claim form is printed in this column fo the provider's reference.
RECIPIENT NAME	The name of the recipient as it appears on the Department' file of eligible Medicaid recipients.
RECIPIENT NUMBER	The Medical Assistance I.D. Number of the recipient as shown on the claim form submitted by the provider.
INTERNAL CONTROL NO.	The internal control number (ICN) assigned to the clai for identification purposes by EDS. The ICN consists of 13 digits and five different identifying components. A detailed example follows.

SECTION VIII - REMITTANCE STATEMENT

98 - 90 - 219 - 400 - 020
1 2 3 4 5

1 - Region Code
98 - UB-82 Crossovers
10 - Electronic Media
50 - Adjustment
60 - Mass Adjustment

2 - Calendar Year
1990

3 - Julian Date
219 = August 7

4 - Batch Range
400-499 = Claims without attachments
860-899 = Claims with attachments
800-849 = Crossover Claims

5 - Document Number
This number indicates the claim location within a batch (020 is the third claim).

DATES OF SERVICE	The earliest and latest dates of service as shown on the claim form.
TOTAL CHARGES	The total charges billed by the provider for the services on this claim form.
PROFESSIONAL COMPONENT	That portion of the charges billed by the provider that represents the professional component payable by the Program.
AMT. FROM OTHER SRCS	The amount indicated by the provider as received from a source other than the Medicaid Program for services on the claim.
CLAIM PMT AMOUNT	The amount being paid by the Medicaid Program to the provider for this claim.

EOB — For explanation of benefit code, see back page of Remittance Statement.

INPATIENT

ACCOM/ANCIL — The accommodation and ancillary charges.

QTY — The number of procedures/supply for that line item charges.

LINE NO. — The number of the line on the claim being printed.

LINE ITEM — The charge submitted by the provider for the procedure

PROF COMP — That portion of the charges billed by the provider that represents the professional component payable by the Program for that line item.

EOB — Explanation of benefit code which identifies the payment process used to pay the line item.

All items printed have been previously defined in the descriptions of the paid claims section in the inpatient paid claims section of the Remittance Statement.

OUTPATIENT

PS — Place of service code depicting the location of the rendered service.

TS — Type of service code depicting the type of service.

PROC — The procedure code in the line item.

D. Section II - Denied Claims

The second section of the Remittance Statement appears whenever claims are rejected in total. This section lists all such claims and indicates the EOB code explaining the reason for each claim rejection. Appendix XVI

All items printed have been previously defined in the descriptions of the paid claims section of the Remittance Statement.

E. Section III - Claims in Process

The third section of the Remittance Statement (Appendix XVI) lists those claims which have been received by EDS but which were not adjudicated as of the date of this report. A claim in this category usually has been suspended from the normal processing cycle because of data errors or the need for further review. A claim appears in the Claims In Process section of the Remittance Statement at the time of its suspension and again at the time of the last processing cycle of the month, if the claims remains in a suspended status. At the time a final determination can be made as to claim disposition (payment or rejection), the claim will appear in Section I or II of the Remittance Statement.

F. Section IV - Returned Claims

The fourth section of the Remittance Statement (Appendix XVI) lists those claims which have been received by EDS and returned to the provider because required information is missing from the claim. The claim has been returned to the provider with a cover sheet which indicates the reason(s) that the claim has been returned.

G. Section V - Claims Payment Summary

This section is a summary of the claims payment activities as of the date indicated on the Remittance Statement and YTD claim payment activities.

CLAIMS PAID/ DENIED	The total number of finalized claims which have been determined to be denied or paid by the Medicaid program, as of the date indicated on the Remittance Statement and YTD summation of claim activity.
AMOUNT PAID	The total amount of claims that paid as of the date on the Remittance Statement and the YTD summation of payment activity.
WITHHELD AMOUNT	The dollar amount that has been recouped by Medicaid as of the date on the Remittance Statement (and YTD summation of recouped monies).

NET PAY AMOUNT	The dollar amount that appears on the check.
CREDIT AMOUNT	The dollar amount of a refund that a provider has sent to EDS to adjust the 1099 amount (this amount does not affect claims payment, it only adjusts the 1099 amount).
NET 1099 AMOUNT	The total amount of money that the provider has received from the Medicaid program as of the date on the Remittance Statement and the YTD total monies received taking into consideration recoupments and refunds.

H. Section VI - Description of Explanation Codes Listed Above

Each EOB code that appeared on the dated Remittance Statement will have a corresponding written explanation pertaining to payment, denial, suspension and return for a particular claim (Appendix XVI).

SECTION IX - GENERAL INFORMATION - EDS

A. Correspondence Forms Instructions

TYPE OF INFORMATION REQUESTED	TIME FOR INQUIRY	MAILING ADDRESS
Inquiry	6 weeks after billing	EDS P.O. Box 2009 Frankfort, KY 40602 Attn: Communications Unit
Adjustment	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 Attn: Adjustments Unit
Refund	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Cash and Finance Unit

TYPE OF INFORMATION REQUESTED	NECESSARY INFORMATION
Inquiry	1. Completed Inquiry Form 2. Remittance Statement or Medicare EOMB, when applicable 3. Other supportive documentation, when needed, e.g., a photocopy of the Medicaid claim when a claim has not appeared on a Remittance Statement within a reasonable amount of time

TYPE OF INFORMATION REQUESTED	NECESSARY INFORMATION
Adjustment	1. Completed Adjustment Form 2. Photocopy of the claim in question 3. Photocopy of the applicable portion of the Remittance Statement in question

TYPE OF INFORMATION REQUESTED	NECESSARY INFORMATION
Refund	1. Cash Refund Documentation 2. Refund Check 3. Photocopy of the applicable portion of the Remittance Statement in question

B. Telephone Inquiry Information

WHAT IS NEEDED?

-Provider number
-Patient's Medicaid ID number
-Date of service
-Billed amount
-Your name and telephone number

WHEN TO CALL?

-When claim is not showing on paid, pending or denied sections of the Remittance Statement within 6 weeks
-When the status of claims is needed and they do not exceed five in number

WHERE TO CALL?

-Toll-free number 1-800-756-7557 (within Kentucky)
-Local (502) 227-2525

C. Filing Limitations

NEW CLAIMS — 12 months from date of service

MEDICARE AND MEDICAID CROSSOVER CLAIMS	12 months from date of service NOTE: If the claim is a Medicare crossover claim and is received by EDS more than 12 months from date of service, but less than 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and will proceed with claims processing.
THIRD-PARTY LIABILITY CLAIMS	12 months from date of service NOTE: If the other insurance company has not responded within 120 days of the date a claim is submitted to the insurance company, submit the claim to EDS indicating "NO RESPONSE" from the other insurance company.
ADJUSTMENTS	12 months from date the paid claim appeared on the Remittance Statement

D. Provider Inquiry Form

The Provider Inquiry form shall be used for inquiries to EDS regarding paid or denied claims, billing concerns, and claim status. If requesting more than one claim status, a Provider Inquiry form shall be completed for each status request. The Provider Inquiry form shall be completed in its entirety and mailed to the following address:

EDS
P.O. Box 2009
Frankfort, KY 40602

Supplies of the Provider Inquiry form may be obtained by writing to the above address or contacting EDS Provider Relations Unit at 1-(800)-756-7557 or 1-(502)-227-2525.

Please remit BOTH copies of the Provider Inquiry form to EDS. Any additional documentation that would help clarify your inquiry shall be attached. EDS shall enter their response on the form and the yellow copy shall be returned to the provider.

It is NOT necessary to complete a Provider Inquiry form when resubmitting a denied claim.

Provider Inquiry forms shall NOT be used in lieu of the Medicaid Program claim forms, Adjustment forms, or any other document required by the Medicaid Program.

In certain cases it may be necessary to return the Inquiry form to the provider for additional information if the inquiry is illegible or unclear.

Instructions for completing the Provider Inquiry form are found below.

FIELD NUMBER	INSTRUCTIONS
1	Enter the 8-digit Kentucky Medicaid Provider Number.
2	Enter the Provider Name and Address.
3	Enter the Medicaid recipient's name as it appears on the Medical Assistance Identification Card.
4	Enter the recipient's 10 digit Medical Assistance Identification number.
5	Enter the billed amount of the claim on which you are inquiring.

FIELD NUMBER	INSTRUCTIONS
6	Enter the claim service date(s).
7	If you are inquiring in regard to an in-process, paid, or denied claim, enter the date of the Remittance Statement listing the claim.
8	If you are inquiring in regard to an in-process, paid, or denied claim, enter the 13-digit internal control number listed on the Remittance Statement for that particular claim.
9	Enter your specific inquiry.
10	Enter your signature and the date of the inquiry.

E. Adjustment Request Form

The Adjustment Request form is to be used when requesting a change on a previously paid claim. This does not include denied claims or claims returned to the provider for requested additional information or documentation.

For prompt action and response to the adjustment requests, please complete all items. COPIES OF THE CLAIM AND THE APPROPRIATE PAGE OF THE REMITTANCE STATEMENT MUST BE ATTACHED TO THE ADJUSTMENT REQUEST FORM. If items are not completed, the form may be returned.

FIELD NUMBER	DESCRIPTION
1	Enter the 13-digit ICN number for the particular claim in question.
2	Enter the recipient's name as it appears on the Remittance Statement (last name first).
3	Enter the complete recipient identification number as it appears on the Remittance Statement. The complete Medicaid number contains 10 digits.

FIELD NUMBER	DESCRIPTION
4	Enter the provider's name, address and complete provider number.
5	Enter the "From Date of Service" for the claim in question.
6	Enter the "To Date of Service" for the claim in question.
7	Enter the total charges submitted on the original claim.
8	Enter the total Medicaid payment for the claim as found under the "Claims Payment Amount" column on the Remittance Statement.
9	Enter the Remittance Statement date which is found on the top left corner of the remittance. Please do not enter the date the payment was received or posted.
10	Specifically state WHAT is to be adjusted on the claim (i.e. date of service, units of service).
11	Specifically state the reasons for the requested adjustment (i.e. miscoded, overpaid, underpaid).
12	Enter the name of the person who completed the Adjustment Request Form.
13	Enter the date on which the form was submitted,

Mail the completed Adjustment Request form, claim copy and Remittance Statement to the address on the top of the form.

To reorder these inquiry forms contact the Communications Unit by mail:

EDS
P.O. Box 2009
Frankfort, KY 40602

Be sure to specify the number of forms you desire. Allow 7 days for delivery.

F. Cash Refund Documentation Form

The Cash Refund Documentation form shall be completed when a provider sends a refund check. The completed form and a copy of the remittance statement page showing the paid claim being refunded shall accompany the check. Please mail to the following address:

EDS
P.O. Box 2009
Attn: Financial Services
Frankfort, KY 40602

If a check is sent without the Cash Refund Documentation form, the check will not be posted to a specific claim. Thisaction would not reflect the refund being made for a particular claim, possibly leaving the provider responsible for another refund at a later date. If there are any quest ions concerning the form, please call the Provider Relations Unit at 1-800-756-7557or l-(502)-227-2525.

FIELD NUMBER	DESCRIPTION
1	Enter the check number
2	Enter the amount of the check
3	Enter the provider name, provider number and address
4	Enter the name of recipient on claim being refunded
5	Enter the recipient's Medicaid identification number (10 numeric digits)

6	Enter the "From Date of Service" on claim being refunded
7	Enter the "To Date of Service" on claim being refunded
8	Enter the date of the Paid Remittance Statement on which the claim appears
9	Enter the 13-digit Internal Control Number (ICN) of the particular claim for which you are refunding. This is listed on the "Paid Claims" page of your remittance statement. (If several ICN's are to be applied to one check, they can be listed on the same form only if they have the same reason for refund explanation)

REASON FOR REFUND

Check the appropriate reason for which the claim is being refunded. Be sure to complete all blanks. The example listed below shows how each refund reason is to be completed accurately. Only one reason can be completed per Cash Refund Documentation form. If multiple claims with multiple refund reasons are included in one check, complete a separate form for each refund reason.

_____a. Payment from other source - check the category and list name
_____ Health Insurance (attach a copy of EOB)
_____ Auto Insurance
_____ Medicare paid
_____ Other

_____b. Billed in error

_____c. Duplicate payment (attach a copy of both Remittance Statements. If Remittance Statements are paid to 2 different providers specify to which provider number the check is to be applied.

_____d. Processing error or Overpayment

Explain why

_____

_____e. Paid to wrong provider

_____f. Money has been requested - date of the letter (Attach a copy of letter requesting money)

_____g. Other

Contact Name Phone

HOSPITAL MANUAL

APPENDIX

DEPARTMENT FOR MEDICAID SERVICES

ADVANCED REGISTERED NURSE PRACTITIONER SERVICES

Services by an Advanced Registered Nurse Practitioner shall be payable if the service provided is within the scope of licensure. These services shall include, however not be limited to, services provided by the certified nurse midwife (CNM), family nurse practitioner (FNP), and pediatric nurse practitioner (PNP).

AMBULATORY SURGICAL CENTER SERVICES

Medicaid covers medically necessary services provided in free-standing ambulatory surgical centers.

BIRTHING CENTER SERVICES

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two (2) follow-up postnatal visits within four (4) to six (6) weeks of the delivery date.

DENTAL SERVICES

Coverage shall be limited but includes cleanings, oral examinations, X-rays, fillings, extractions, palliative treatment of oral pain, hospital and emergency calls for recipients of all ages. Other preventive dental services (i.e. root canal therapy) and Comprehensive Orthodontics are also available to recipients under age twenty-one (21).

DURABLE MEDICAL EQUIPMENT

Certain medically-necessary items of durable medical equipment, orthotic and prosthetic devices shall be covered when ordered by a physician and provided by suppliers of durable medical equipment, orthotics and prosthetics. Most items require prior authorization.

DEPARTMENT FOR MEDICAID SERVICES

EARLY PERIODIC, DIAGNOSIS, AND TREATMENT (EPSDT)

Under the EPSDT program, Medicaid-eligible children, from birth through the end of the birth month of their twenty-second birthday, may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

Medical History
Physical Examination
Growth and Development Assessment
Hearing, Dental, and Vision Screenings
Lab tests as indicated
Assessment or Updating of Immunizations

(EPSDT) SPECIAL SERVICES PROGRAM

The EPSDT Special Services Program considers medically necessary items and services that are not routinely covered under the state plan. These services are for children from birth through the end of their twenty-first year. All services shall be prior authorized by the Department for Medicaid Services.

FAMILY PLANNING SERVICES

Comprehensive family planning services shall be available to all eligible Medicaid recipients of childbearing age and those minors who can be considered sexually active. These services shall be offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services also shall be available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, shall be available through the Family Planning Services element of the Kentucky Medicaid Program. Follow-up visits and emergency treatments also shall be provided.

DEPARTMENT FOR MEDICAID SERVICES

HEARING SERVICES

Hearing evaluations and single hearing aids, when indicated, shall be paid for by the program for eligible recipients, to the age of twenty-one (21). Follow-up visits, as well as check-up visits, shall be covered through the hearing services element. Certain hearing aid repairs shall also be paid through the program.

HOME HEALTH SERVICES

Skilled nursing services, physical therapy, speech therapy, occupational therapy, and aide services shall be covered when necessary to help the patient remain at home. Medical social worker services shall be covered when provided as part of these services. Home health coverage also includes disposable medical supplies. Coverage for home health services shall not be limited by age.

HOSPICE

Medicaid benefits include reimbursement for hospice care for Medicaid recipients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance shall also be provided to the patient and family in adjustment to the patient's illness and death. A Medicaid recipient who elects to receive hospice care waives all rights to certain separately available Medicaid services which shall also be included in the hospice care scope of benefits.

HOSPITAL SERVICES

INPATIENT SERVICES

Kentucky Medicaid benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions shall be preauthorized by a Peer Review Organization. Certain surgical procedures shall not be covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital. Elective and cosmetic procedures shall be outside the scope of program benefits unless medically necessary or indicated. Reimbursement shall be limited to a maximum of fourteen (14) days per admission except for services provided to recipients under age six (6) in hospitals designated as disproportionate share hospitals by Kentucky Medicaid and services provided to recipients under age one (1) by all acute care hospitals.

A

OUTPATIENT SERVICES

Benefits of this Program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician, clinic visits, pharmaceuticals covered, emergency room services in emergency situations as determined by a physician, and services of hospital-based emergency room physicians.

There shall be no limitations on the number of hospital outpatient visits or covered services available to Medicaid recipients.

KENTUCKY COMMISSION FOR HANDICAPPED CHILDREN

The Commission provides medical, preventive and remedial services to handicapped children under age twenty-one (21). Targeted Case Management Services are also provided. Recipients of all ages who have hemophilia may also qualify.

DEPARTMENT FOR MEDICAID SERVICES

LABORATORY SERVICES

Coverage of laboratory procedures for Kentucky participating providers includes all Medicaid covered procedures for which the provideris certified by the Clinical Laboratory Improvement Amendments (CLIA) requirements.

LONG TERM CARE FACILITY SERVICES

INTERMEDIATE CARE FACILITY SERVICES **FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED (ICF/MR/DD)**

The Kentucky Medicaid Program shall make payment to intermediate care **facilties** for the mentally retarded and developmentally disabled for services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age twenty-two **(22),** who because of their mental and physical condition require care and services which are not provided by community resources.

The need for the **ICF/MR/DD** level of care shall be certified by the Kentucky Medicaid Peer Review Organization (PRO).

NURSING **FACILITY SERVICES**

The Department for Medicaid Services shall make payment for services provided to Kentucky Medicaid eligible residents of nursing facilities which have been certified for participation in the Kentucky Medicaid Program. The need for admission and continued stay shall be certified by the Kentucky Medicaid Peer Review Organization (PRO). The Department shall make payment for Medicare deductible and coinsurance amounts for those Medicaid residents who are also Medicare beneficiaries.

DEPARTMENT FOR MEDICAID SERVICES

MENTAL HEALTH SERVICES

COMMUNITY MENTAL HEALTH CENTER SERVICES

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

Outpatient Services
Psychosocial Rehabilitation
Emergency Services
Inpatient Services
Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health center and possibly avoid hospitalization. There are fourteen (14) major centers, with many satellite centers available. The Kentucky Medicaid Program also reimburses psychiatrists for psychiatric services through the physician program.

MENTAL HOSPITAL SERVICES

Reimbursement for inpatient psychiatric services shall be provided to Medicaid recipients under the age of twenty-one (21) and age sixty-five (65) or older in a psychiatric hospital. There shall be no limit on length of stay; however, the need for inpatient psychiatric hospital services shall be verified through the utilization control mechanism.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Inpatient psychiatric residential treatment facility services are limited to residents age six (6) to twenty-one (21). Program benefits are limited to eligible recipients who require inpatient psychiatric residential treatment facility services on a continuous basis as a result of a severe mental or psychiatric illness. There is no limit on length of stay; however, the need for inpatient psychiatric residential treatment facility services must be verified through the utilization control mechanism.

DEPARTMENT FOR MEDICAID SERVICES

TARGETED CASE MANAGEMENT SERVICES

ADULTS Case management services are provided to recipients eighteen (18) years of age or older with chronic mental illness who need assistance in obtaining medical, educational, social, and other support services.

CHILDREN Case management services are provided to Severely Emotionally Disturbed (SED) children who need assistance in obtaining medical, educational, social, and other services.

NURSE ANESTHETIST SERVICES

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist shall be covered by the Kentucky Medicaid Program.

NURSE MIDWIFE SERVICES

Medicaid reimbursement shall be available for covered services performed by and within the scope of practice of certified registered nurse midwives through the Advanced Registered Nurse Practitioner Program.

PHARMACY SERVICES

Legend and non-legend drugs from the approved Medical Assistance Outpatient Drug List when required in the treatment of chronic and acute illnesses shall be covered. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and providers upon request and routinely sent to participating pharmacies and nursing facilities. The Drug List is distributed periodically with monthly updates. Certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization shall be covered for payment through the Drug Preauthorization Program.

In addition, nursing facility residents may receive other drugs which may be prior authorized as a group only for nursing facility residents.

PHYSICIAN SERVICES

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, selected vaccines and RhoGAM, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms shall be completed prior to coverage of these procedures.

Non-covered services include:

Most injections, supplies, drugs (except anti-neoplastic drugs), cosmetic procedures, package obstetrical care, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:

Certain types of office exams, e.g. new patientcomprehensive office visits, shall be limited to one (1) per twelve (12) month period, per patient, per physician.

PODIATRY SERVICES

Selected services provided by licensed podiatrists shall be covered by the Kentucky Medicaid Program. Routine foot care shall becovered only for certain medical conditions where the care requires professional supervision.

PREVENTIVE HEALTH SERVICES

Preventive Health Services shall be provided by health department or districts which have written agreements with the Department for Health Services to provide preventive and remedial health care to Medicaid recipients.

PRIMARY CARE SERVICES

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits shall be generally applicable when the services are provided by a primary care center.

RENAL DIALYSIS CENTER SERVICES

Free-standing renal dialysis center benefits include renal dialysis, certain supplies and home equipment.

RURAL HEALTH CLINIC SERVICES

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasizes preventive and maintenance health care for people of all ages. The clinics, though physician directed, shall also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

TRANSPORTATION SERVICES

Medicaid shall cover transportation to and from Medicaid Program covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered shall be preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services when provided by a participating medical transportation provider. Travel to pharmacies shall not be covered,

VISION SERVICES

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists shall be covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs shall be covered for eligible recipients under age twenty-one (21).

DEPARTMENT FOR MEDICAID SERVICES

SPECIAL PROGRAMS

ALTERNATIVE INTERMEDIATE SERVICES FOR THE MENTALLY RETARDED

The Alternative Intermediate Services for the Mentally Retarded (AIS/MR) home-and community-based services project provides coverage for an array of community based services that shall be an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD).

HOME AND COMMUNITY BASED WAIVER SERVICES

A home- and community-based services program provides Medicaid coverage for a broad array of home- and community-based services for elderly and disabled recipients. These services shall be available to recipients who would otherwise require the services in a nursing facility. The services became available statewide effective July 1, 1987. These services shall be arranged for and provided by home health agencies.

KenPAC

The Kentucky Patient Access and Care System, or KenPAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medical Assistance Only shall be covered under KenPAC. The recipient shall choose the physician or clinic. It is especially important for the KenPAC recipient to present his or her Medical Assistance Identification Card each time a service is received.

SPECIAL HOME- AND COMMUNITY-BASED SERVICES MODEL UAIVER PROGRAM

The Model Waiver Services Program provides up to sixteen (16) hours of private duty nursing services and respiratory therapy services to disabled ventilator dependent Medicaid recipients who would otherwise require the level of care provided in a hospital-based skilled nursing facility. This program shall be limited to no more than fifty (50) recipients.

ELIGIBILITY INFORMATION

PROGRAMS

The Department for Social Insurance, Division of Field Services local office staff have primary responsibility for accepting and processing applications for benefit programs administered by the Cabinet for Human Resources, Department for Social Insurance. These programs, which include eligibility for Medicaid, include:

AFDC (Aid to Families with Dependent Children)
AFDC Related Medical Assistance
State Supplementation of the Aged, Blind, or Disabled
Aged, Blind, or Disabled Medical Assistance

Any individual has the right to apply for Medicaid and have eligibility determined. Persons wanting to apply for Medicaid benefits shall be referred to the local Department for Social Insurance, Division of Field Services office in the county in which they live. Persons unable to visit the local office may write or telephone the local office for information about making application. For most programs, a relative or other interested party may make application for a person unable to visit the office.

In addition to the programs administered by the Department for Social Insurance, persons eligible for the federally administered Supplemental Security Income (SSI) program also receive Medicaid through the Kentucky Medical Assistance Program. Eligibility for SSI is determined by the Social Security Administration. Persons wanting to apply for SSI shall be referred to the Social Security Administration office nearest to the county in which they live. The SSI program provides benefits to individuals who meet the federal definitions of age, blindness, or disability, in addition to other eligibility requirements.

MAID CARDS

Medical Assistance Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month-to-month eligibility period.

Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend down" case receive one (1) MAID card

indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend down" eligibility period.

MAID cards may show a retroactive period of eligibility. Depending on the individual circumstances of eligibility, the retroactive period shall include several months.

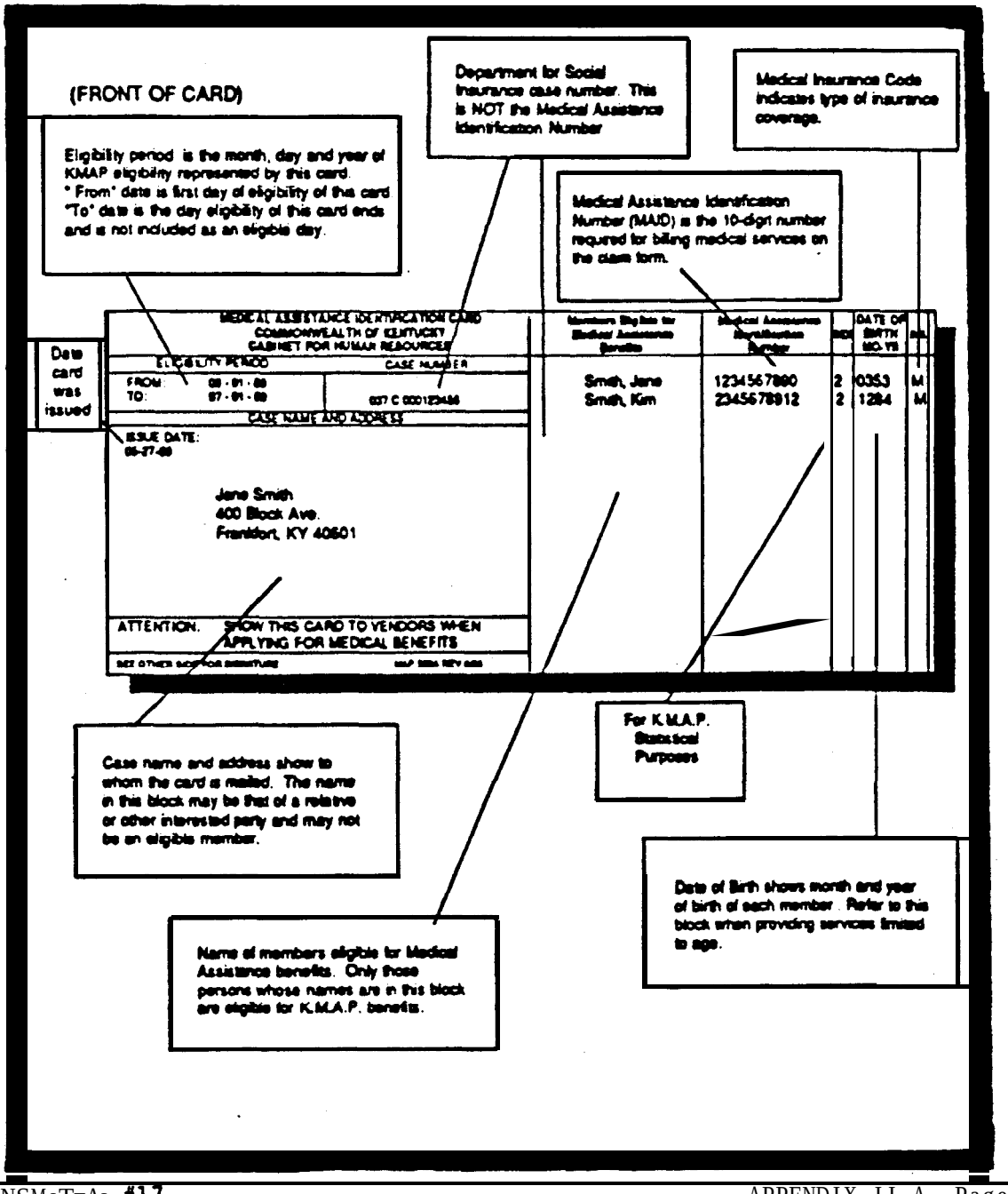
Duplicate MAID cards may be issued for individuals whose original card is lost or stolen. The recipient should report the lost or stolen card to the local Department for Social Insurance, Division of Field Services worker responsible for the case.

VERIFYING ELIGIBILITY

The local Department for Social Insurance, Division of Field Services staff may provide eligibility information to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564-6885 shall also verify eligibility for providers.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

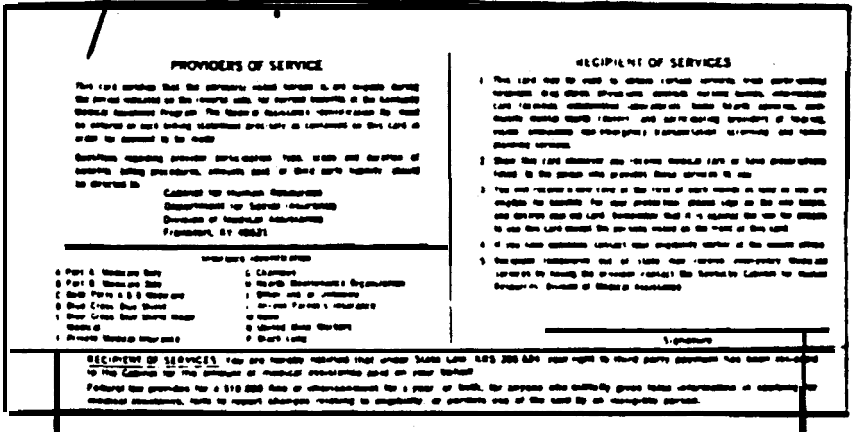


CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(BACK OF CARD)

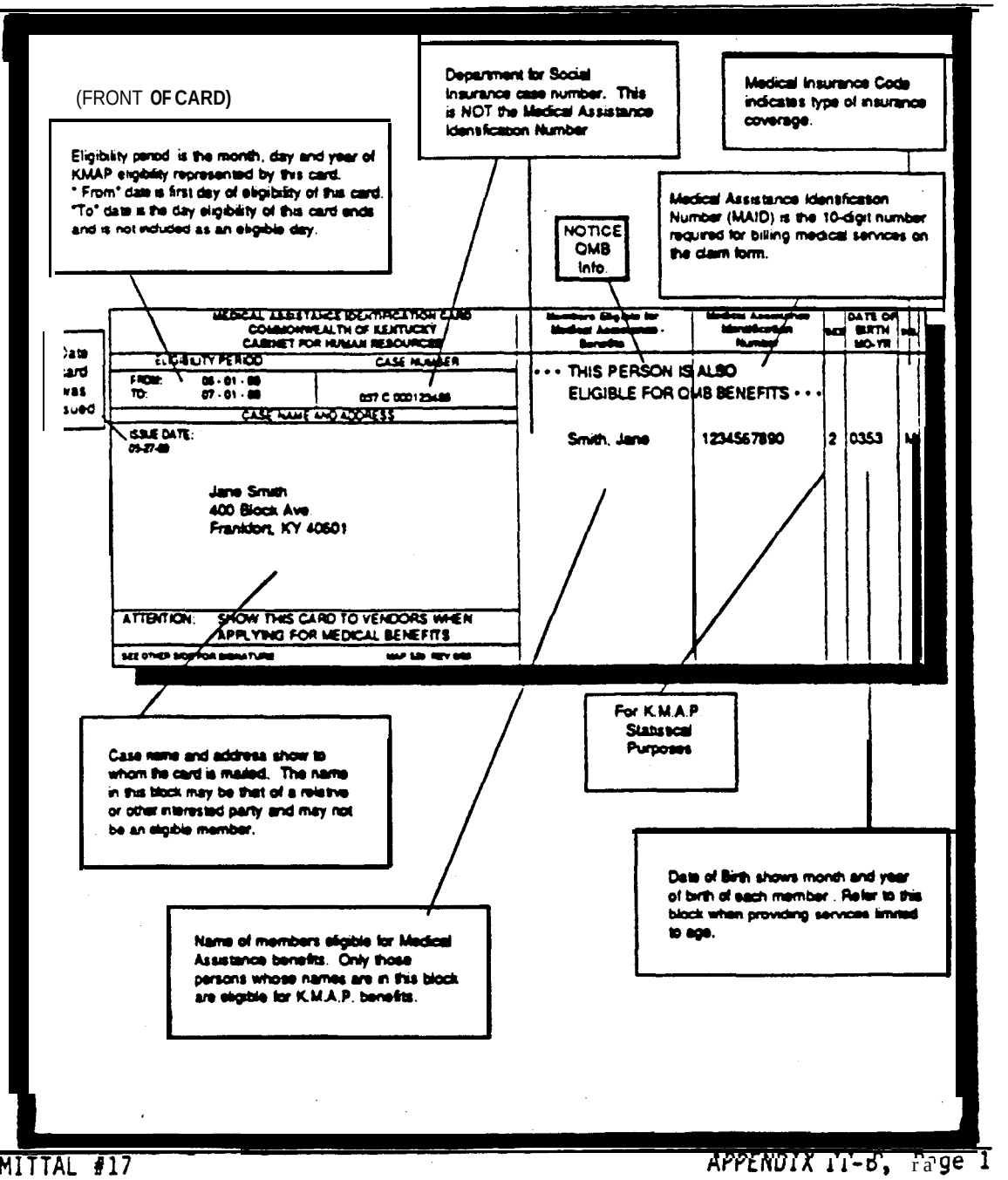
Information to Providers. Insurance Identification codes indicate type of insurance coverage as shown on the front of the card in "Ins" block.



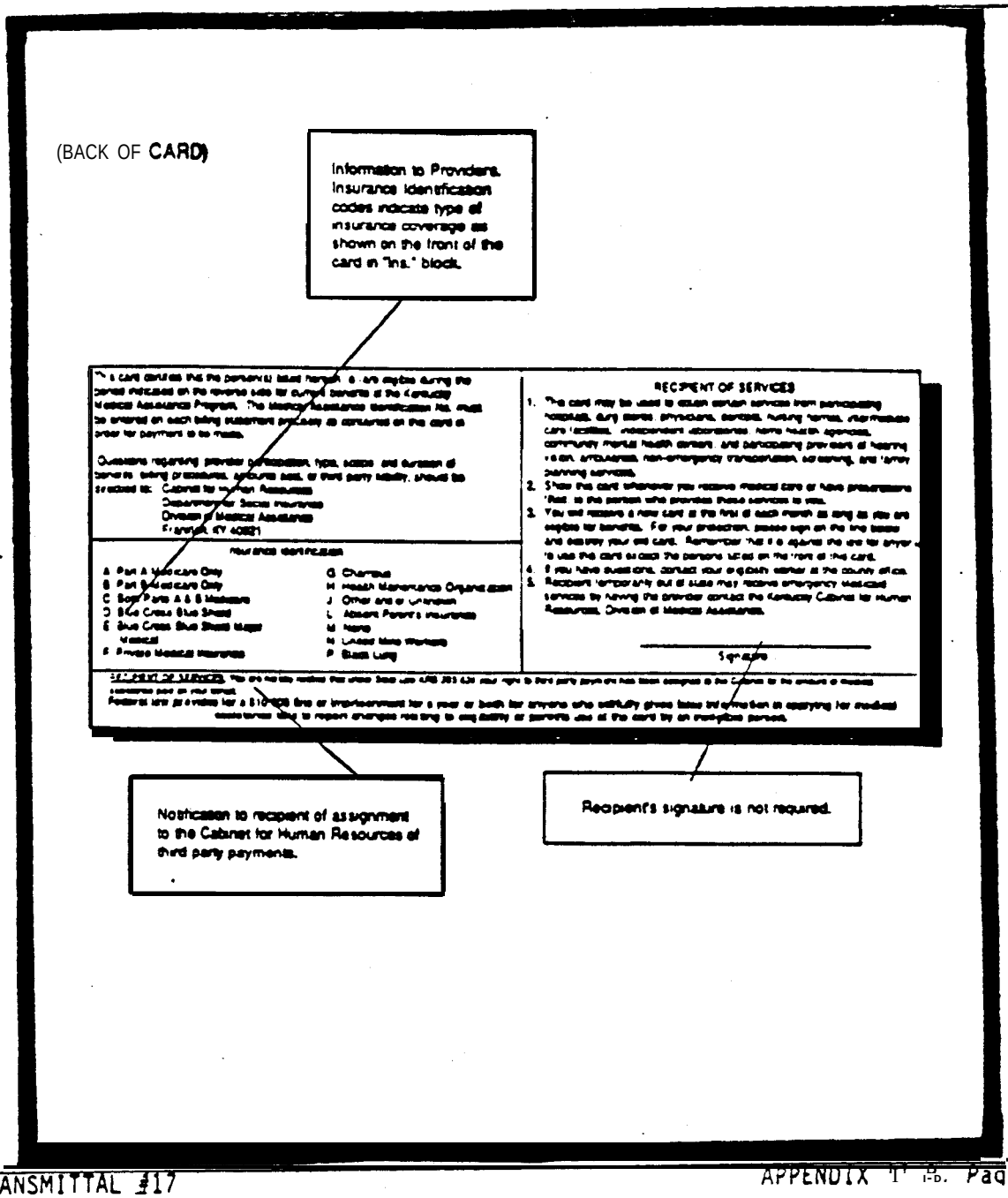
Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

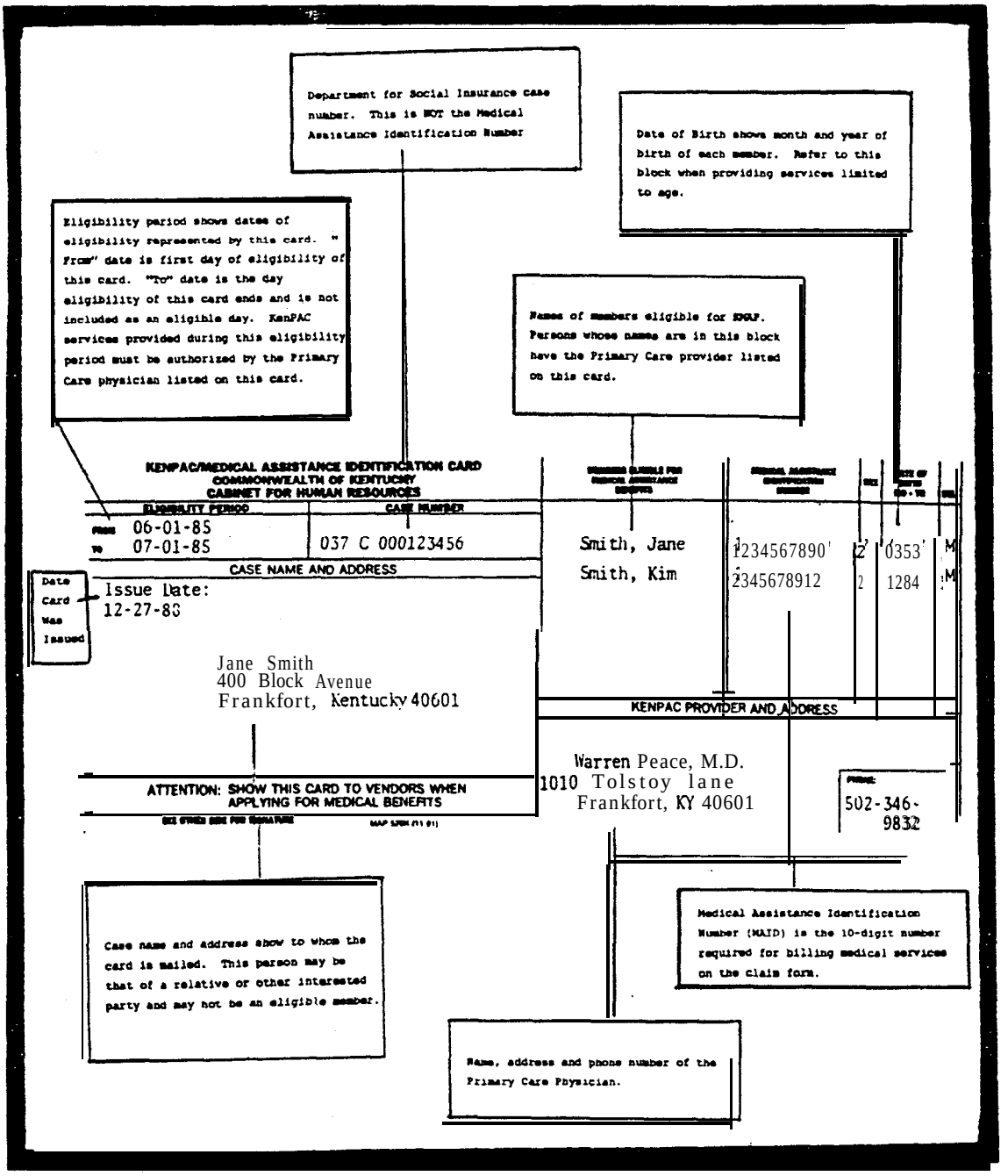
KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD



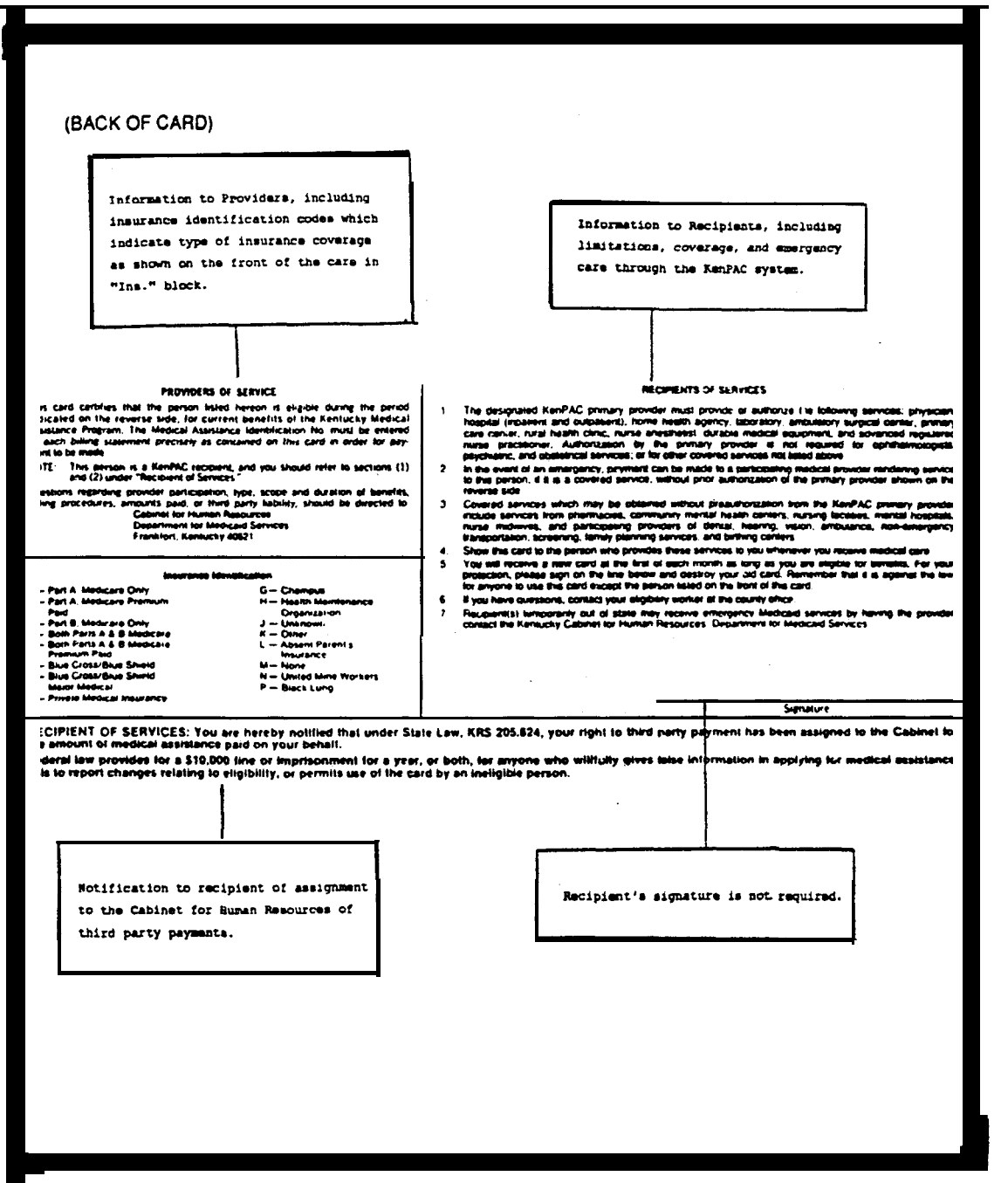
KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./O.M.B.) CARD



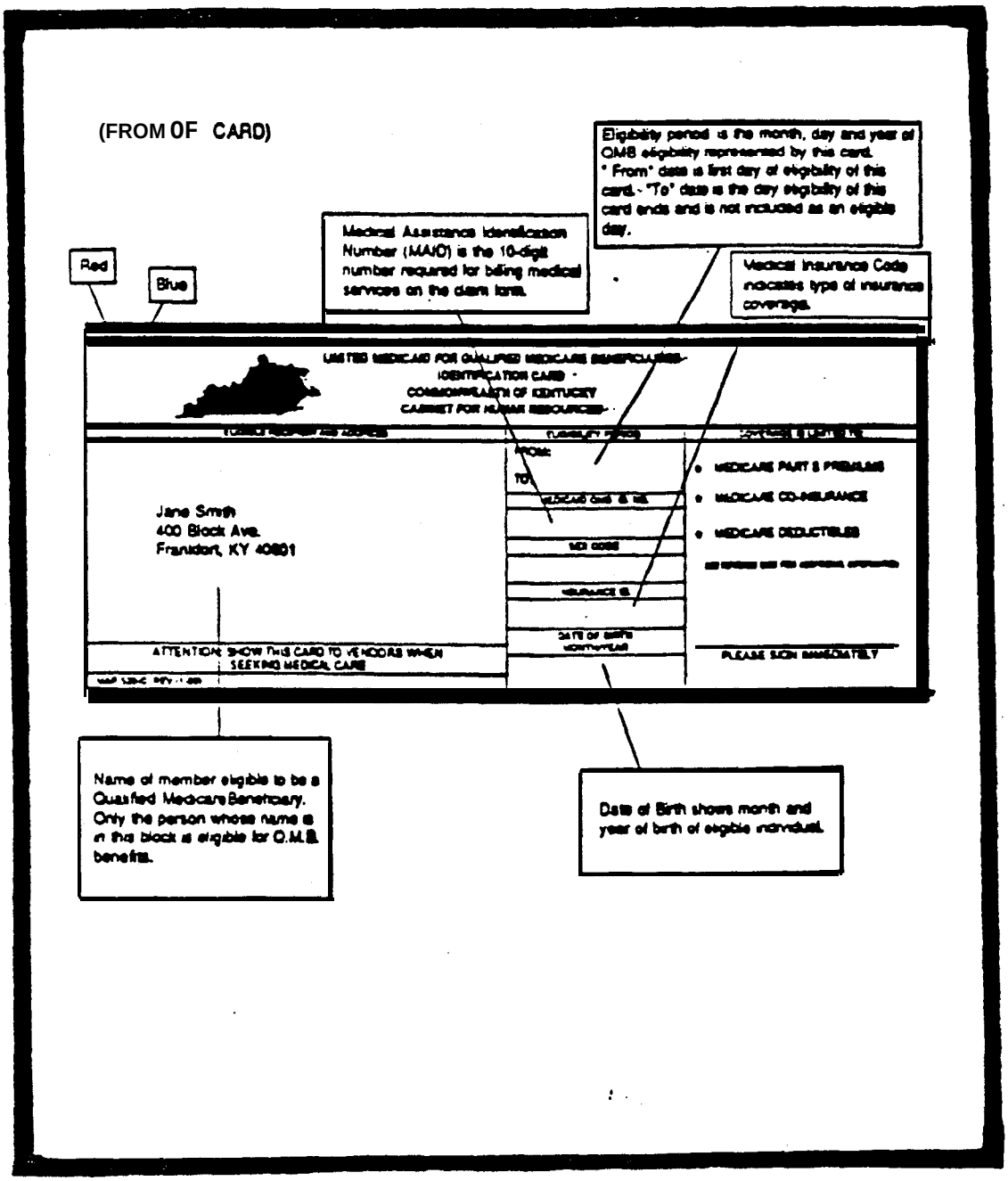
KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM



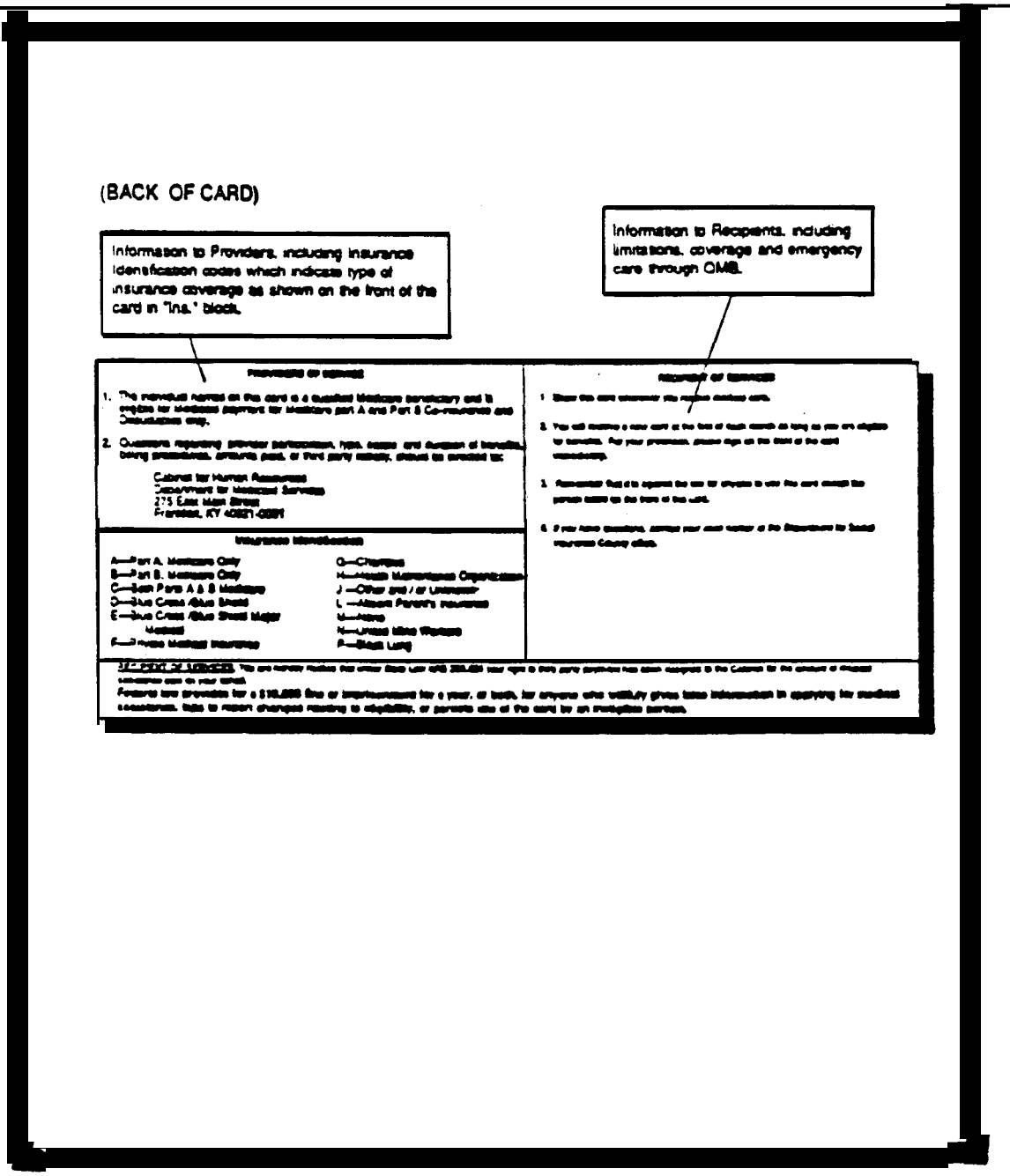
KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM



OUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (O.M.B.) CARD



QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B.) CARD



PROVIDER AGREEMENT

Any hospital wishing to participate in the Medicaid Program shall submit a Provider Agreement (MAP-343). The signing of a Provider Agreement does not commit the facility to participate but indicates the intent to participate. The Provider Agreement does not become a legal contract until the facility has been approved and the Provider Agreement has been signed by the authorized official, Department for Medicaid Services.

A. The Provider Agreement (MAP-343) is to be reviewed by the governing body, completed by the authorized representative of the facility having authority to commit the facility to the terms of the contract, and the original and yellow copy submitted to Provider Enrollment, Department for Medicaid Services. The yellow copy will be returned to the facility when certification is completed.

B. INSTRUCTIONS FOR COMPLETING THE PROVIDER AGREEMENT

Provider Number -- Will be completed by the Medicaid Program.

Lines l-2 -- Enter the date on which the agreement is submitted.

Line 4 -- Enter the name of the facility as it appears on the license.

Line 5 -- Enter the address of the actual location of the facility.

Under the "WITNESSETH, THAT:" section, enter type of provider, **e.g.** acute care hospital, in the two (2) spaces indicated.

Page three, item 5 will be completed by the Medicaid Program after the facility has been certified.

Page three, "PROVIDER" section shall be signed and completed by the authorized representative of the facility.

PROVIDER AGREEMENT (MAP-343)

MAP-343 (Rev. 5/86)

Provider Number: _____
(If Known)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as Of the ____ day Of _____, 19___, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provider)

_____
(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

_____
(Type Of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies Jnd procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

(3) Agrees to comply 4th the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or Jge in the provision Of services.)

PROVIDER AGREEMENT (MAP-343)

MAP-343 (Rev. 5/86)

(4) Agrees to maintain such records as are necessary to disclose the extent of services furnished to Title XIX recipients for a minimum of 5 years and for such additional time as may be necessary in the event of an audit exception or other dispute and to furnish the Cabinet with any information requested regarding payments claimed for furnishing services.

(5) Agrees to permit representatives of the state and/or federal government to have the right to examine, inspect, copy and/or audit all records pertaining to the provision of services furnished to Title XIX recipients. (Such examinations, inspections, copying and/or audits may be made without prior notice to the Provider.)

(6) Assures that he (it) is aware of Section 1909 of the Social Security Act; Public Law 92-603 (As Amended), reproduced on the reverse side of this Agreement and of KRS 194.500 to 194.990 and KRS 205.845 to 205.855 and 235.990 relating to medical assistance fraud.

(7) Agrees to inform the Cabinet for Human Resources, Department for Medicaid Services, within 30 days of any change in the following:

(a) name;
(b) ownership;
(c) licensure/certification/regulation status; or
(d) address.

(8) Agrees not to discriminate in services rendered to eligible Title XIX recipients on the basis of marital status.

(9) (a) In the event that the Provider is a specialty hospital providing services to persons aged 65 and over, home health agency, or a skilled nursing facility, the Provider shall be certified for participation under Title XVIII of the Social Security Act.

(b) In the went that the Provider is a specialty hospital providing psychiatric services to persons age 21 and under, the Provider shall be approved by the Joint Commission on Accreditation of Hospitals. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Hospitals.

(10) In the event that the provider desires to participate in the physician or dental clinic/corporation reimbursement system, Kentucky Medical Assistance Program payment for physicians' or dentists' services provided to recipients of the Kentucky Medical Assistance Program will be made directly to the clinic/corporation upon proper issuance by the employed physician or dentist of a Statement of Authorization (MAP-347).

This clinic/corporation does meet the definition established for participation and does hereby agree to abide by all rules, regulations, policies and procedures pertaining to the clinic/corporation reimbursement system.

2. In consideration of approved services rendered to Title XIX recipients certified by the Kentucky Medical Assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees, subject to the availability of federal and state funds, to reimburse the Provider in accordance with current applicable federal and state laws, rules and regulations and policies of the Cabinet for Human Resources. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services.

PROVIDER AGREEMENT (MAP-343)

MAP-343 (Rev. 5/86)

3. Either party shall have the right to terminate this agreement at any time upon 30 days' written notice served upon the other party by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, may terminate this agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or certified mail with return receipt requested.

4. In the event of a change of ownership of an SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.

5. In the event the named Provider in this agreement is an SNF, ICF, or ICF/MR/DD this agreement shall begin on _____, 19___, with conditional termination on _____, 19___, and shall automatically terminate on _____, 19___, unless the facility is recertified in accordance with applicable regulations and policies.

PROVIDER

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

CERTIFICATION ON LOBBYING (MAP-343 A)

MAP-343 A
(11/91)

CERTIFICATION ON LOBBYING
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

The undersigned Second Party certifies, to the best of his or her knowledge and belief, that for the preceding contract period, if pny, and for this current contract period:

1. Ho Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awardlng of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperatlve agreement.

2. If any funds other thdn Federal appropriated funds have been paid or will be paid to any person for influencing or dttemptlng to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with it8 instructions.

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (Including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify dnd disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, U.S. Code. Any person who falls to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

SIGNATURE : _____

NAME: _____

TITLE: _____

DATE: _____

PROVIDER INFORMATION

Each hospital shall complete a Provider Information form (MAP-344) and submit it as requested. Any changes in submitted information are to be reported in writing to Provider Enrollment, Department for Medicaid Services as the changes occur.

INSTRUCTIONS FOR COMPLETING THE PROVIDER INFORMATION FORM (MAP-344)

1. Enter the name of the facility as shown on the facility license and the county of location.
2-3. Enter mailing address.
4. Enter telephone number, including area code.
5. Enter the name of the person, agency or corporation to whom payment is to be made.
6. If address of payee is different from facility as listed on lines 2-3, enter the address of payee.
7. Enter Federal Employer ID number.
8. Not applicable.
9. Enter number as shown on facility license.
10. Enter name of the facility licensing board.
11. Enter original facility license date of the present owner.
12. Enter provider number assigned by the Medicaid Program, if known.
13. Enter hospital Medicare provider number, if known.
14. Check the applicable types of practice organization structure.
15.-16. Not applicable.
17. Enter the name of corporation owning the facility, address and telephone number of Home Office. Give names and addresses of corporation officers (attach a continuation sheet if necessary).
18. Enter names and addresses of partners in a partnership (attach a continuation sheet if necessary).
19-21. Not applicable.
22. Check only one block under this section.
23. Enter the fiscal year ending date as established by the facility.
24-28. Self-explanatory.
29. Self-explanatory;add continuation sheet if additional space is necessary.
30. Enter the name and home office address of the firm managing the facility if different from ownership.
31. Self-explanatory.

32. Enter the number of licensed beds, as shown on license for their corresoondino acute care, and total beds certified under Title XIX.
33. Not applicable.
34. **Self-explanatory.** If additional space is needed, use a continuation **sheet.**
35. Not applicable.
36. Not applicable.
37. Enter signature of person authorized by facility to submit information. Type or print name of authorized person below the signature with his or her title.

PROVIDER INFORMATION (MAP-344)

MAP-344 (Rev. 3/91)

Kentucky Medicaid Program

Provider Information

1. _____ (Name) _____ (County)

2. _____ (Location Address, Street, Route No, P.O. Box)

3. _____ (City) (State) (Zip)

4. _____ (Office Phone# of Provider)

5. _____ (Pay to, In care of, Attention, etc. If different from above address.)

6. _____ Pay to address (If different from above)

7. federal Employee ID No. _____

8. Social Security No. _____

9. License No. _____

10. Licensing Board (If applicable): _____

11. Original license date: _____

12. Kentucky Medicaid Provider No. (If known) _____

13. Medicare Provider No. (If applicable) _____

14. Practice Organization/Structure: (1) Corporation
___ (2) Partnership ___(3) Individual
___ (4) Sole Proprietorship ___ (5) Public Service Corporation
___ (6) Estate/Trust ___ (7) Government/Non-Profit

15. Are you a hospital based physician (salaried or under contract by a hospital)? yes ___ no
Name of hospital(r) _____

1

PROVIDER INFORMATION (MAP-344)

16. If group practice, number of providers in group (specify provider type): _____

17. If corporation, name, address, and telephone number of corporate office: _____

_____

Telephone No: _____

Name and address of officers:

_____

_____

_____

_____

18. If partnership, name and address of partners:

_____

_____

_____

_____

19. National Pharmacy No. (If applicable): _____
(Seven-digit number assigned by the National Council for Prescription Drug Programs.)

20. Physician/Professional Specialty Certification Board (submit copy of Board Certificate):
1st _____ Date _____

2nd _____ Date _____

21. Name of Clinic(s) in which Provider is a member:
1st _____

2nd _____

3rd _____

4th _____

22. Control of Medical Facility:
___ Federal ___ State ___County ___City
___ Charitable or religious
___ Proprietary (Privately-owed) _ Other

2

PROVIDER INFORMATION (MAP-344)

23. Fiscal Year End: _____

24. Administrator: _____ Telephone No. _____

25. Assistant Admin: _____ Telephone No. _____

26. Controller: _____ Telephone No. _____

27. Independent Accountant or CPA: _____
Telephone No. _____

28. If sole proprietorship, name, address, and telephone number of owner:

_____

_____

29. If facility is government owned, list names and addresses of board members:

President or Chairman of Board:

_____

Member: _____

Member: _____

30. Management Firm (If applicable):

_____

31. Lessor (If applicable):

_____

32. Distribution of beds in facility:

	Total licensed Beds	Total Kentucky Medicaid Certified Beds
Acute Care Hospital		
Psychiatric Hospital		
Nursing facility		
MR/DD		

33. Nf or MR/DD owners with 5% or more ownership:

Name	Address	% of Ownership

3

PROVIDER INFORMATION (MAP-344)

34. Institutional Review Committee Members (If applicable):

_____

_____

35. Providers of Transportation Services:
Number of Ambulances in Operation:
Number of Wheelchair Vans in Operation: ___
Basic Rate $_____ (Includes up to ___ miles)
Per Mile $_____ Oxygen $_____
Extra Patient $_____ Other $_____

36. Has this application been completed as the result of a change of ownership of a previously enrolled fledicaid provider? ___ yes ___ no

37. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that mdy be sought in connectron with my application for participation in the Kentucky Medicaid Program.

Signature: _____

Name: _____

Title: _____

Return all enrollment fonns, changes and inquiries to:

Medicaid-Provider Enrollment
Third floor East
275 East Main Street
frankfort, KY 40621

INTER-OFFICE USE ONLY
License Number Verified through _____ (Enter Code)

Comments: _____

Date: _____ Staff: _____

4

STATEMENT OF AUTHORIZATION (MAP-347)

MAP.347
(02/86)

KENTUCKY MEDICAL ASSISTANCE PROGRAM
STATEMENT OF AUTHORIZATION

I hereby declare that I, _____,
(Licensed Professional)

a duly-licensed _____, have entered into a

contractual agreement with _____
(Clinic/Corporation or Facility Name)

_____
(City, State, & Zip Code)

to provide professional services. I authorize payment to

_____
(Clinic/Corporation or Facility Name)

from the Kentucky Medical Assistance Program for covered services provided by me and specified by the criteria of our contract. I understand that I, personally, cannot bill the Kentucky Medical Assistance Program for any service that is

reimbursed to _____
(Clinic/Corporation or Facility Name)

as part of our contractual agreement, and that I am solely and completely responsible for all Kentucky Medical Assistance Program documents submitted by this employer in my name for services I provided.

_____ _____
Signature of Professional Date Signed

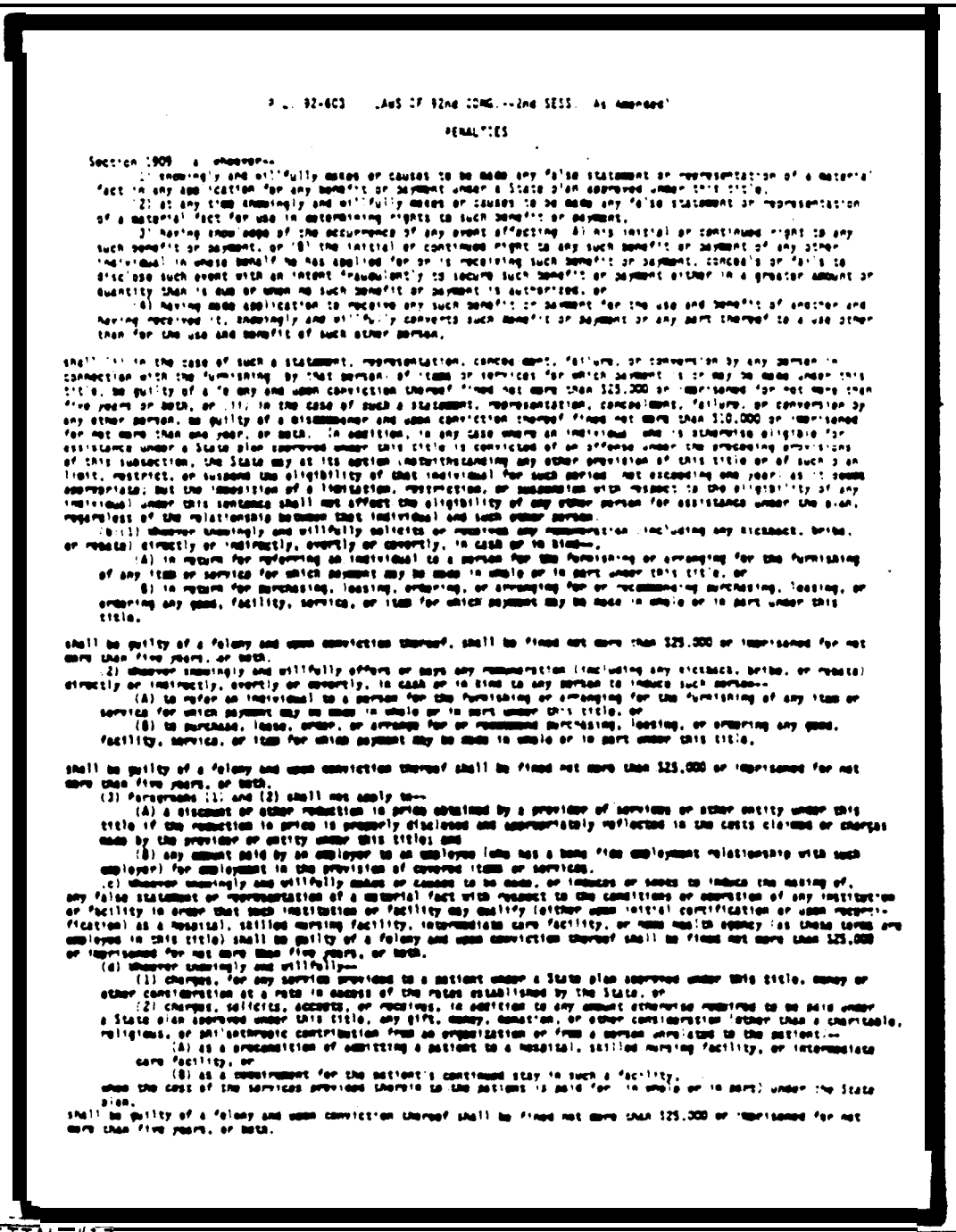
_____ _____
License and/or Certification Number Specialty

_____
Social Security Number

_____
Federal Employer Identification Number

_____
KMAP Provider Number of
Clinic/Corporation or Facility

STATEMENT OF AUTHORIZATION (MAP-347)



P .. 92-603 .AWS OF 92nd CONG.--2nd SESS. As Amended

PENALTIES

Section 1909 a whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing by that person of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such a plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b) (1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any services provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

CERTIFICATION FOR ABORTION OR MISCARRIAGE (MAP-235)

CERTIFICATION FORM FOR INDUCED ABORTION
OR INDUCED MISCARRIAGE

I, _____, certify that on the basis of my
Physician's Name

professional judgment, the life of _____
Patient's Name

_____ at _____
MAID # Patient's Address

would be endangered lf the fetus were carried to ten. I further certify that the following procedure(s) was medically necessary to Induce the abortion or miscarriage.

(Please indicate date and the procedure thatwas performed.) _____

_____

_____

_____
Physician Signature

_____
License Number

_____
Date

MAP-235 (7/78)

CERTIFICATION FOR PREMATURE BIRTH (MAP-236)

CERTIFICATION FORM FOR INDUCED PREMATURE BIRTH

I, _____, certify that an the basis of
Physicrrn's Name

my professional judgement, it was necessary to perform the following procedure on _____ to induce premature birth intended to
Date

produce a live viable child. _____
Procedure

This procedure, was necessary for the health of _____
kdme of Mother

_____ of _____
MAID # Adorers

and/or her unborn child.

_____
Physician's Signature

_____
Name of Physician

_____
License Number

_____
Date

MAP-236 (7/78)

STERILIZATION CONSENT FORM (MAP-250)

MAP 250
(1-79)

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____. Before I have asked for the operation I was told that the decision to be sterilized is entirely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A F D C or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about these temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and choose to be sterilized.

I understand that I will be sterilized by an operation known as _____. The benefits, risks and discomforts associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____.
(Month Day Year)

I, _____, hereby consent of my own free will to be sterilized by _____.
(Physician)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about this operation to:

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department that give me family planning or Federal aid, where I am receiving.

I have received a copy of this form.

_____ Date _____
(Signature) (Month Day Year)

You are requested to supply the following information, but it is not required.

Race and ethnic origin

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have explained the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form on _____, the language I used is one he/she understands fully. To the best of my knowledge and belief he/she understands this explanation.

_____ Date _____
(Interpreter)

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed this consent form, I explained to him/her the nature of the sterilization which _____ this fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I informed the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that he/she has the right to withdraw at any time and that he/she will not lose any Federal services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She understands sterilization and sterilization is desired to be performed and appears to understand the nature and consequences of the procedure.

_____
(Signature of person obtaining consent) Date

_____
(Position)

_____
(Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on _____.
(Name of individual to be sterilized) (Date of sterilization)

_____. I explained to him/her the nature of the operation _____ the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.
(Type of kind of operation)

I informed the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that he/she has the right to withdraw at any time and that he/she will not lose any Federal services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She understands sterilization and sterilization is desired to be performed and appears to understand the nature and consequences of the procedure.

Hysterectomy or removal of reproductive tissue accomplishes this sterilization in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In these cases, the following paragraph should be used. Cross out the paragraph which is not used.

(1) At least thirty days have passed between the date of this individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check appropriate box and fill in information requested):

- ☐ Premature delivery.
- ☐ Individual's expected date of delivery:
- ☐ Emergency abdominal surgery.

_____
(Physician) Date

3. State Agency, Program or Project

COMPLETION OF "CONSENT FORM," (MAP-250)

Completion of "Consent Form," MAP-250

1. Purpose

Federal regulations (42 CFR 441.250-441.258) require any individual being sterilized to read and sign a federally approved consent form with information about the procedure and the results of the procedure. Form MAP-250, "Consent Form" or another form approved by the Secretary of Health and Human Services, provides this documentation and Program policy requires that it be signed by the recipient, the person obtaining the consent, and the physician. Refer to Section IV for Program policies pertaining to sterilizations.

2. General Insturctions

The "Consent Form" (MAP-250) is a 5-part form.

All blanks shall be completed.

The following individuals or offices shall receive a copy of the completed MAP-250 form:

- -the surgeon, to attach to the surgeon's claim form;
- -the assistant surgeon, to attach to the assistant surgeon's claim form;
- -The anesthesiologist, to attach to the anesthesiologist's claim form;
- -the hospital, to attach to the hospital claim form; and
- -the recipient.

Additional copies of the completed MAP-250' form shall be made for documentation purposes, if necessary.

Attach the signed and dated form MAP-250 behind the corresponding claim form and submit for processing.

COMPLETION OF "CONSENT FORM," (MAP-250)

MAP-250 forms can be ordered from:

Department for Medicaid Services
CHR Building, 3rd Floor East
275 East Main Street
Frankfort, KY 40621

3. Detailed Instructions for Completion of Form

IMPORTANT: The recipient's current Kentucky Medical Assistance Identification card shall be checked for 1) date of birth (remember recipient shall be at least 21 years of age at the time consent is given), and 2) to assure sex code is correct (1 male, 2 female). The claim will be denied if the sex code on the eligibility card is inappropriate for the procedure performed.

a. Consent to Sterilization

Enter the name of the physician or clinic who expects to perform the procedure.

Enter the name of the procedure to be performed.

Enter the birthdate of the recipient.

Enter the name of the recipient.

Enter the name of the physician expected to perform the procedure.

Enter the method of sterilization.

The recipient signs the form.

Enter the date the recipient signs the form.

Race and ethnicity information may be designated by checking the appropriate block.

b. Interpreter's Statement

If appropriate, complete this section at the same time the above section is completed.

Enter the language used to read and explain the form.

The interpreter signs and dates the form.

c. Statement of Person Obtaining Consent

This section is completed at the same time or after the above two sections are completed.

Enter the recipient's name.

Enter the procedure name.

The person obtaining the consent reads, signs, and dates the form. This date shall be on or after the date the recipient signed.

Enter the name and address of the facility or office of the person obtaining consent.

d. Physician Statement

This section is completed at the same time or after the procedure is performed.

Enter the name of the recipient and the date of the sterilization.

Enter the name of the procedure performed.

COMPLETION OF "CONSENT FORM," (MAP-250)

If the sterilization was performed less than 30 days but more than 72 hours after date of the individual's signature on the Consent Form, check the applicable block and provide the information requested.

In the case of premature delivery, enter the expected date of delivery. The expected date of delivery shall be at least 30 days after the individual's signature date.

If the procedure was performed as a result of emergency abdominal surgery, enter a brief description in the designated area of the Consent Form, or attach an operative report to describe the circumstances.

The physician who performed the procedure signs the form. The actual signature of the physician is required.

Enter the date the physician signs the form. This date shall be on or after the date of the surgery.

CABINET FOR HUMAN RESOURCES
OEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES MANUAL

HYSTERECTOMY CONSENT FORM (MAP-251)

MAP-251
(1-79)

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR HUMAN RESOURCES
BUREAU FOR SOCIAL INSURANCE

HYSTERECTOMY CONSENT FORM

NOTICE: YOUR DECISION At ANY TIME **NOT TO** HAVE A HYSTERECTOMY **WILL** NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

I, _____ , hm requested and received information about
(print or type)

hysterectomies (abdominal and/or vaginal) from _____
(name of attending physician)

I was informed that a hysterectomy is the surgical removal of the uterus/womb and of the two (2) methods of performing the procedure (abdominal hysterectomy and vaginal hysterectomy).

I have been advised of the type of hysterectomy procedure (abdominal and/ or vaginal) that will be performed on me. I am aware of the complications that mrv result from the performance of this surgical procedure.

I was informed that a hysterectomy is intended to be J permanent/final and irreversible procedure. I understand that I will be unable to become pregnant of bur children.

I certify that I fully understand the above and voluntarily consent to the surgical procedure.

Signature of Patient/
Representative _____

Signature of Person
Obtaining Consent _____

Date _____

COMPLETION OF "HYSTERECTOMY CONSENT FORM," MAP-251

Completion of "Hysterectomy Consent Form," MAP-251

1. Purpose

Federal regulations (42 CFR 441.250-441.258) require any individual receiving a hysterectomy to read and sign a federally approved consent form with information about the procedure and the results of the procedure. Form MAP-251 or another form approved by the Secretary of Health and Human Services, provides that documentation and shall be signed by the individual receiving the hysterectomy or her representative, EXCEPT IN CIRCUMSTANCES DESCRIBED IN SECTION IV OF THIS MANUAL.

2. General Instructions

The "Hysterectomy Consent Form" (MAP-251) is a 5-part form.

All blanks shall be completed.

The following individuals or offices shall receive a copy of the completed MAP-251 form:

- the surgeon, to attach to the surgeon's claim form;
- the assistant surgeon, to attach to the assistant surgeon's claim form;
- the anesthesiologist, to attach to the anesthesiologist's claim form;
- the hospital, to attach to the hospital claim for; and
- the recipient or her representative, for her records.

Additional copies of the completed MAP-251 form shall be made for documentation purposes, if necessary.

Attach the signed and dated form MAP-251 behind the corresponding claim form and submit for processing. When a hysterectomy is performed on an individual who is already sterile, or who required a hysterectomy because of a life-threatening emergency, attach the physician's written certification behind the claim form and submit for processing.

COMPLETION OF "HYSTERECTOMY CONSENT FORM," MAP-251

MAP-251 forms can be ordered from:

Department for Medicaid Services
CHR Building, 3rd Floor East
275 East Main Street
Frankfort, KY 40621

3. Detailed Instructions for Completion of the Form

Enter the name of the recipient.

Enter the name of the physician providing information about the hysterectomy.

The recipient or her representative reads and signs the form.

The person obtaining consent signs and dates the form.

The dates cannot be after the date of the surgery. Please refer to Section IV, page 4.5, Item #9 for instructions involving retroactive eligibility or emergency situations.

THIRD PARTY LIABILITY PROVIDER LEAD FORM

(REV. 7/91)

THIRD PARTY LIABILITY
LEAD FORM

Recipient Name : _____ MAID #_____

Date of Birth : _____ Address: _____

Date of Service : _____ To:_____

Date of Admission: _____ Date of Discharge: _____

Name of Insurance Company: _____

Address :_____

Policy #: _____ Start Date: _____ End Date:_____

Date Filed with Carrier : _____

Provider Name : _____ Provider #: _____

Comments: _____

Signature:*_____ Date:_____

CERTIFICATION OF CONDITIONS MET (MAP-346)

MAP-346
(7/92)

KENTUCKY MEDICAID PROGRAM
CERTIFICATION OF CONDITIONS HET
FACILITY-BASED MEDICAL PROFESSIONALS REMUNERATION
AS AN ELEMENT OF FACILITY'S REIMBURSABLE COST

This is to certify that each of the Listed licensed medical professionals has entered into financial arrangements with _____
(FACILITY NAME)

_____, for the purpose of providing
(CITY) (STATE)
his/her services to patients of this facility, and that currently on file in this facility is a Statement of Authorization (MAP-347) executed by each of these individuals which authorizes payment by the Kentucy Medicaid Program to _____ for services provided to eligible Kentucky Medicaid
(FACILITY)
Program recipients.

NAME	PROFESSIONAL'S MEDICARE NUHBER	PROFESSIONAL'S LICENSE NUMBER	SPECIALTY	DATE Of FACILITY EHPLOYHENT

SIGNATURE: _____

NAHE: _____

DATE: _____

KENTUCKY MEDICAID
Provider#: _____

OTHER HOSPITALIZATION STATEMENT (MAP-383)

MAP-383 (03/87)

OTHER HOSPITALIZATION STATEMENT

This is to certify thdt hospitdlirdtion dt

_____
Name Of Facility

for _____ beginning on
Recipient Name/MAID Number

_____ is not reldted to the terminal illness of
Date of Admission

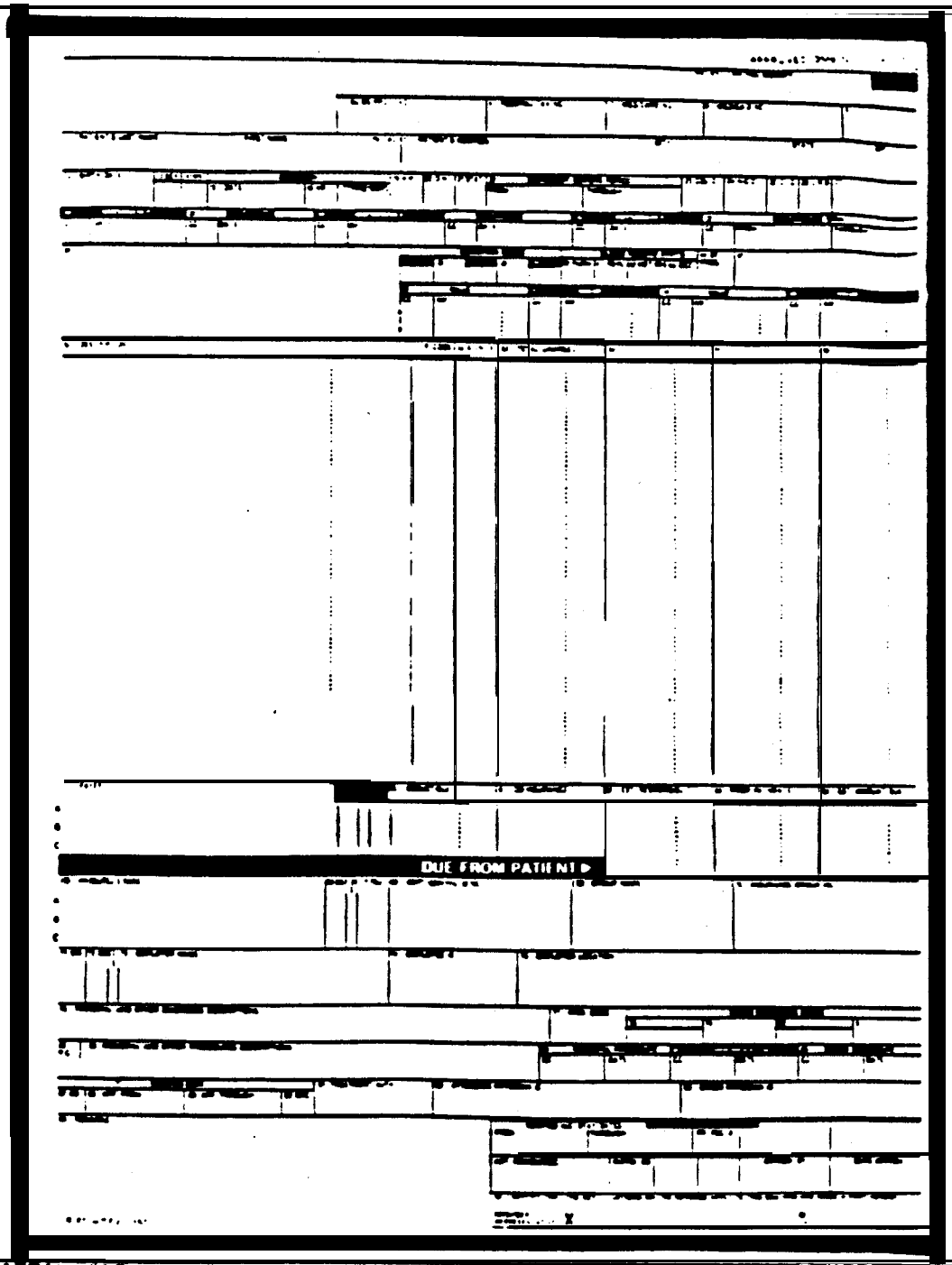
this patient. Charges for this hospital stay should not be billed to the hospice agency but should be billed directly to the Kentucky Medical Assistance Progra.

Signed: _____
Medical Director

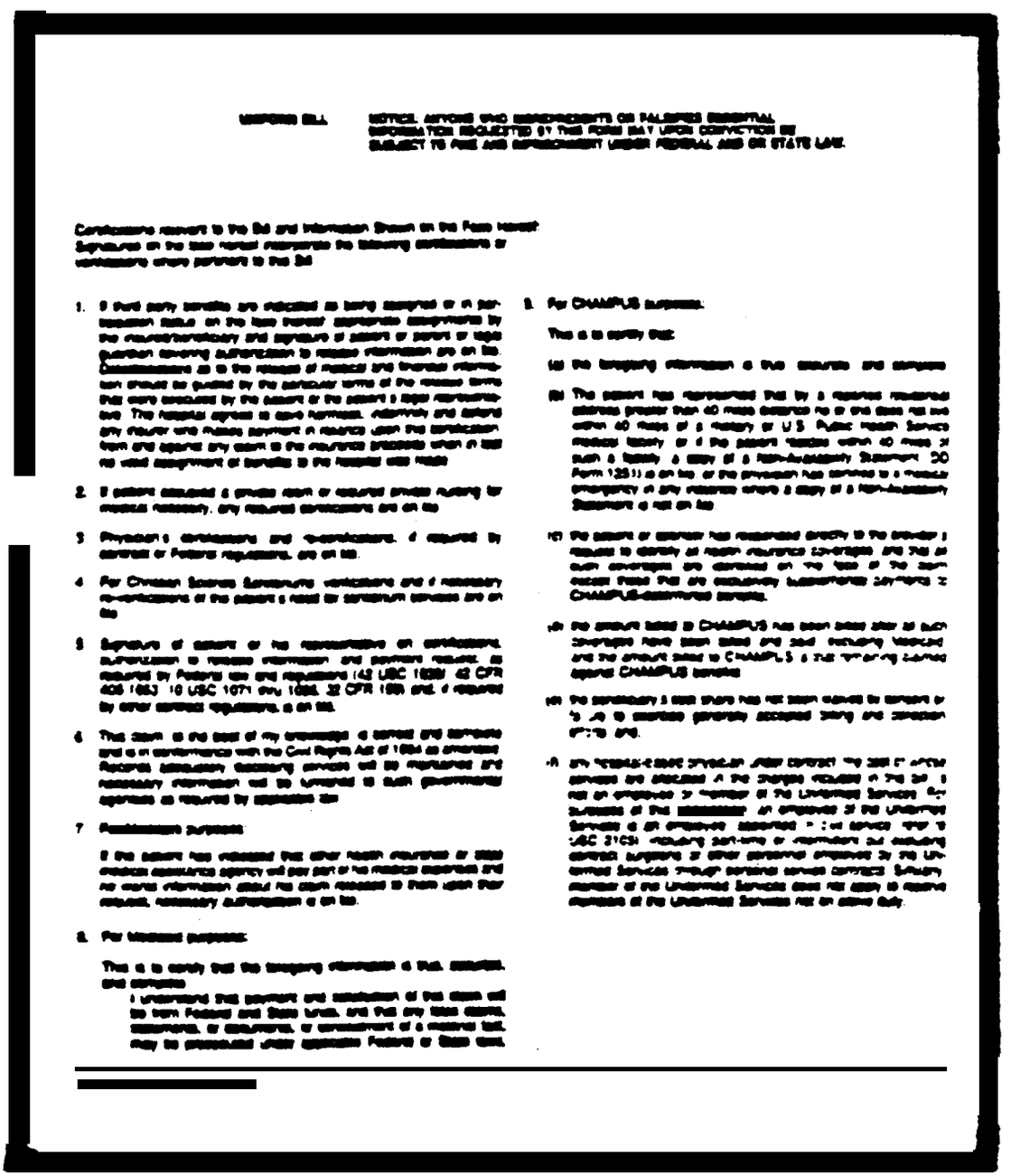
_____
Hospice Agency

_____
Date

UNIFORM BILLING FORM (UB-82 HCFA-1450)



UNIFORM BILLING FORM (UB-82 HCFA-1450)



PROVIDER AGREEMENT ADDENDUM (MAP-380)

MAP-380 (Rev. 04/90)

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Agreement Electronic Media Addendum

This addendum to the Provider Agreement is made and entered into as of the ____ day of _____, 19___, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____,
Name and Address of Provider
hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above-named Provider participates in the Kentucky Medical Assistance Program (KMAP) as a

_____, _____
(Type of Provider and/or Level of Care) (Provider Number)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

   A. Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP.

   B. Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent.

   C. Acknowledges that the Provider's signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media:

   "This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal and State Law."

PROVIDER AGREEMENT ADDENDUM (MAP-380)

MAP-380 (Rev. 04/90)
Page 2

D. Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet.

E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately.

F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force.

G. Agrees to refund to the State the processing fee incurred for processing any electronic media billing submitted with an error rate of 25% or greater.

2. The Cabinet:

A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies.

B. Agrees to assign to the provider or its agent a code to enable the media to be processed.

C. Reserves the right of billing the provider the processing fee incurred by the Cabinet for all claims submitted by any electronic media billing that are found to have a 25% or greater error rate.

Either party shall have the right to terminate this Addendum upon written notice without cause.

PROVIDER

BY:_____
Signature of Provider

Contact Name:_____

Title:_____

Date:_____

Telephone No.:_____

Software Vendor
and/or Billing Agency:_____

Media:_____

CABINET FOR HUMAN RESOURCES
Department for Medicaid Services

BY:_____
Signature of Authorized Official
or Designee

Name:_____

Title:_____

Date:_____

-2-

AGREEMENT BETWEEN KMAP AND ELECTRONIC MEDIA BILLING AGENCY (MAP-246)

(MAP-246, Rev. 10-86)

Agreement Between the
Kentucky Medical Assistance Program
and
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medical Assistance Program.

The _____ has
(Name of Billing Agency)
entered into a contract with _____,
(Name of Provider)
_____, to submit claims via electronic media for
(Provider Number)
services provided to KMAP recipients. The billing agency agrees:

1. To safeguard information about Program recipients as required by state and federal laws and regulations;

2. To maintain a record of all claims submitted for payment for a period of at least five (5) years;

3. To submit claim information as directed by the provider, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to defraud or deceive, makes, or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.

4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMAP or its agents.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;

2. To reimburse the provider in accordance with established policies.

This agreement may be terminated upon written notice by either party without cause.

_____
Signature, Authorized Agent of Billing Agency

_____
Date

_____
Signature, Representative of the
Department for Medicaid Services

_____
Date

REMITTANCE STATEMENT

AS OF 8/10/90 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT PAGE 2

RA NUMBER 002844811
RA SEQ NUMBER 40

GENERAL HOSPITAL
PROVIDER NUMBER

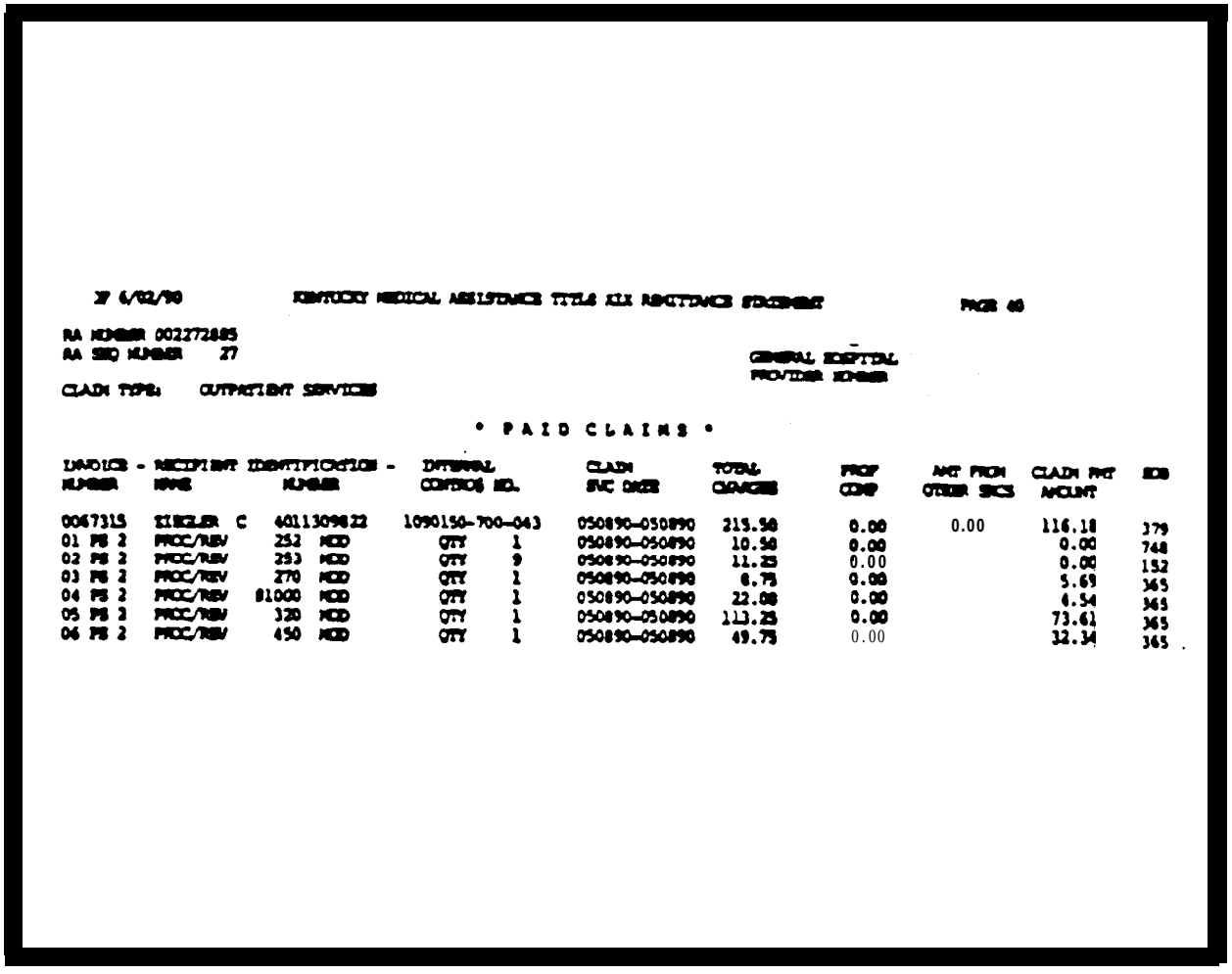
CLAIM TYPE: INPATIENT SERVICES

* P A I D C L A I M S *

INVOICE NUMBER	RECIPIENT NAME	IDENTIFICATION NUMBER	INTERNAL CONTROL NO.	DATES OF SERVICE	TOTAL CHARGES	PROF COMP	AMT FROM OTHER SRCS	CLAIM PMT AMOUNT	EOB
0269153	JONES D		9890211-868-290	052890-052890	225.16	0.00	0.00	365.66	365
01 REV CODE	120	MOD	QTY 1	052890-052990	130.00	0.00		0.00	000
02 REV CODE	250	MOD	QTY 3	052890-052990	11.04	0.00		0.00	000
03 REV CODE	270	MOD	QTY 2	052890-052990	4.20	0.00		0.00	000
04 REV CODE	300	Km	QTY 5	052890-052990	51.92	0.00		0.00	000
05 REV CODE	500	MOD	QTY 1	052890-052990	28.00	0.00		0.00	35!

CLAIMS PAID IN THIS CATEGORY: I TOTAL BILLED: 225.16 TOTAL PAID: 3SR.60

REMITTANCE STATEMENT



[redacted] 6/02/90 [redacted] PAGE 46

RA NUMBER 002272885
RA SEQ NUMBER 27

GENERAL HOSPITAL
PROVIDER NUMBER

CLAIM TYPE: OUTPATIENT SERVICES

• P A I D C L A I M S •

INVOICE - RECIPIENT IDENTIFICATION - NUMBER	NAME	NUMBER		INTERNAL CONTROL NO.		CLAIM SVC DATE	TOTAL CHARGES	PROF COMP	AMT FROM OTHER SRCS	CLAIM PMT AMOUNT	RDB
0067315	ZIEGLER C	401130922		1090150-700-043		050890-050890	215.50	0.00	0.00	116.18	379
01 PS 2	PROC/REV	252	MOD	QTY	1	050890-050890	10.50	0.00		0.00	748
02 PS 2	PROC/REV	253	MOD	QTY	9	050890-050890	11.25	0.00		0.00	152
03 PS 2	PROC/REV	270	MOD	QTY	1	050890-050890	8.75	0.00		5.69	365
04 PS 2	PROC/REV	81000	MOD	QTY	1	050890-050890	22.00	0.00		4.54	365
05 PS 2	PROC/REV	320	MOD	QTY	1	050890-050890	113.25	0.00		73.61	365
06 PS 2	PROC/REV	450	MOD	QTY	1	050890-050890	49.75	0.00		32.34	365

REMITTANCE STATEMENT

AS OF 6/02/90 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT PAGE 24

RA NUMBER 002272885
RA SEQ NUMBER 27

GENERAL HOSPITAL
PROVIDER NUMBER

CLAIM TYPE: INPATIENT SERVICES

DENIED CLAIMS

INVOICE - RECIPIENT IDENTIFICATION - NUMBER	NAME	NUMBER	INTERNAL CONTROL NO.		CLAIM SVC DATE	TOTAL CHARGES	NON COV.	ECB
4122335	[redacted]	F 4023749072	9890139-866-250		042490-042790	1786.25		022
01 REV CODE	123	MOD	QTY	2	042490-042790	610.00		022
02 REV CODE	252	MOD	QTY	1	042490-042790	495.75		022
03 REV CODE	258	MOD	QTY	1	042490-042790	12.50		022
04 REV CODE	270	MOD	QTY	1	042490-042790	31.50		022
05 REV CODE	272	MOD	QTY	1	042490-042790	122.25		022
06 REV CODE	301	MOD	QTY	1	042490-042790	63.75		022
07 REV CODE	302	MOD	QTY	1	042490-042790	47.25		022
08 REV CODE	305	MOD	QTY	1	042490-042790	30.50		022
09 REV CODE	306	MOD	QTY	1	042490-042790	106.75		022
10 REV CODE	397	MOD	QTY	1	042490-042790	35.00		022
11 REV CODE	324	MOD	QTY	1	042490-042790	83.75		022
12 REV CODE	409	MOD	QTY	1	042490-042790	114.25	114.25	022
13 REV CODE	997	MOD	QTY	1	042490-042790	13.00		022

CLAIM ERRORS: 00/022 01/022 02/022 03/022 04/022 05/022 06/022 07/022 08/022 09/022 10/152

REMITTANCE STATEMENT

AS OF 6/02/90 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT PAGE 46

RA NUMBER 002272885
RA SEQ NUMBER 27

GENERAL HOSPITAL
PROVIDER NUMBER

CLAIM TYPE: OUTPATIENT SERVICES

DENIED CLAIMS

INVOICE NUMBER	RECIPIENT IDENTIFICATION - NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	TOTAL CHARGES	ECS
1006233	STEILER R	404643845	9990139-469-040	042590-042590	170.50	281
01 PS 2	PROC/REV 84450	MOD	QTY 1	042590-042590	11.25	281
02 PS 2	PROC/REV 84045	MOD	QTY 1	042590-042590	47.25	281
03 PS 2	PROC/REV 82205	MOD	QTY 1	042590-042590	47.25	281
04 PS 2	PROC/REV 80033	MOD	QTY 1	042590-042590	46.00	281
05 PS 2	PROC/REV 36415	MOD	QTY 1	042590-042590	3.00	281
06 PS 2	PROC/REV 85022	MOD	QTY 1	042590-042590	15.75	281

PRIVATE INSURANCE INFORMATION

POLICY/GRP NO: 334994-11-002 POLICYHOLDER-NAME: RAIMOND STEILER
INSURANCE CO. ADDRESS: P.O. BOX 5060 611 ENGS DR. STE 300
ARLINGTON, TXENG 760110000

CLAIM ERRORS: 00/281 01/281 02/281 03/281 04/281 05/281 06/281

REMITTANCE STATEMENT

AS OF 01/06/84 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT Page 5

RA NUMBER
RA SEQ NUMBER 2
PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: INPATIENT SERVICES

* CLAIMS IN PROCESS *

INVOICE NUMBER	RECIPIENT NAME	IDENTIFICATION NUMBER	INTERNAL CONTROL NO.	DATES OF SERVICE	TOTAL CHARGES	EDB
8162730	EDEN S	483801118J	9881329-951-037	09/02/82	600.00	260
831785	BOYD J	3232168973	9081329-951-050	09/02/83	600.00	260

CLAIMS PENDING IN THIS CATEGORY: 2 TOTAL BILLED: 1000.00

REMITTANCE STATEMENT

AS OF 01/06/98 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT Page 6

RA NUMBER
RA SEQ NUMBER 2
PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: OUTPATIENT SERVICES

* CLAIMS IN PROCESS: *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	DATES OF SERVICE	TOTAL CHARGES	LOC
836270	EDEN S	4031201118J	9883329-951-037	030298	400.00	260
831785	LOYD J	3432168973	9883324-951-050	030998	600.00	260

CLAIMS PENDING IN THIS CATEGORY: 2 TOTAL BILLED: 1000.00

REMITTANCE STATEMENT

AS OF 01/06/84 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT Page 7

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: INPATIENT SERVICES

* RETURNED CLAIMS *

INVOICE NUMBER	RECIPIENT NAME	IDENTIFICATION NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	LOC
812601	SALEM J	329106603B	988)328-951-000	10048)	999

TOTAL CLAIMS RETURNED IN THIS CATEGORY: 1

CLAIMS PAYMENT SUMMARY

	CLAIMS PAID/DENIED	CLAIMS PD AMT	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
CURRENT PROCESSED	2	750.00	0.00	750.00	0.00	750.00
YEAR-TO-DATE TOTAL	630	11480.00	50.00	11430.00	0.00	11430.00

REMITTANCE STATEMENT

AS OF 01/06/98 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT Page 8

RA NUMBER
RA SEQ NUMBER 2 PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: OUTPATIENT SERVICES

0 RETURNED CLAIMS 0

INVOICE NUMBER	RECIPIENT NAME	IDENTIFICATION NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	ELIG
812601	SALEM J	329106034B	98E3329-451-000	100483	999

TOTAL CLAIMS RETURNED IN THIS CATEGORY: 0

CLAIMS PAYMENT SUMMARY

	CLAIMS PAID/DENIED	CLAIMS PD AMT	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
CURRENT PROCESSED	3	1950.00	0.00	1950.00	0.00	1950.00
YEAR-TO-DATE TOTAL	630	11480.00	50.00	11430.00	0.00	11430.00

REMITTANCE STATEMENT

BA NUMBER 002272885
BA SEQ NUMBER 27

GENERAL HOSPITAL
PROVIDER NUMBER 01234567

CLAIM TYPE: INPATIENT CROSSOVERS

* P A I D C L A I M S *

INVOICE NUMBER	RECIPIENT NAME	IDENTIFICATION NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	DEDUCT AMOUNT	COINSUR. AMOUNT	CLAIM PMT AMOUNT	RSN
2408953	ADCOCK A	4024696138	9890146-811-000	041390-041890	592.00	0.00	592.00	061
01 1	PROC 8	MOD	QTY 1	041390-041890			0.00	000
MEDICARE PAID DATE 051090				MEDICARE APPROVED AMOUNT		0.00		
				MEDICARE PAID AMOUNT		0.00		
4297172	DRUIN L	4075017353	9890146-810-250	020990-022090	592.00	0.00	592.00	061
01 1	PROC 8	MOD	QTY 1	020990-022090			0.00	000
MEDICARE PAID DATE 032990				MEDICARE APPROVED AMOUNT		0.00		
				MEDICARE PAID AMOUNT		0.00		

CLAIMS PAID IN THIS CATEGORY: 4 TOTAL BILLED: 2,240.00 TOTAL PAID: 2,240.00

REMITTANCE STATEMENT .

AS OF 6/02/90 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT PAGE 60

RA NUMBER 002272886
RA SEQ NUMBER 27

GENERAL HOSPITAL
PROVIDER NUMBER 01234567

CLAIM TYPE: INPATIENT SERVICES

* A D J U S T E D C L A I M S *

INVOICE NUMBER	RECIPIENT IDENTIFICATION NAME	NUMBER	INTERNAL CONTROL NO.	DATES OF SERVICE	TOTAL CHARGES	PROF COMP	AMT FROM OTHER SRCS	CLAIM PMT AMOUNT	RSN
0480935									
*** ADJUSTMENT TO CLAIM 9090076416330 ORIGINALLY PAID ON 032090									
FOR RECIPIENT SCHROADER CI RECIPN 406234734									
PROVIDED 011690-012290 BILLED AMOUNT: 2831.23 PAID AMOUNT: 4037.56									
*** NEW CLAIM 90135-301-130									
	SCHROADER C	406234734	5090135-301-130	011690-012290	2831.23	0.00	560.00	4217.56	364
01 REV CODE	111	MOD	QTY 6	011690-012290	2076.00	0.00		0.00	000
02 REV CODE	250	MOD	QTY 1	011690-012290	157.55	0.00		0.00	000
03 REV CODE	258	MOD	QTY 1	011690-012290	214.50	0.00		0.00	000
04 REV CODE	270	MOD	QTY 1	011690-012290	127.42	0.00		0.00	000
05 REV CODE	301	MOD	QTY 3	011690-012290	76.35	0.00		0.00	000
06 REV CODE	305	MOD	QTY 12	011690-012290	90.25	0.00		0.00	000
07 REV CODE	307	MOD	QTY 1	011690-012290	7.00	0.00		0.00	000
08 REV CODE	335	MOD	QTY 11	011690-012290	77.44	0.00		0.00	000
09 REV CODE	997	MOD	QTY 1	011690-012290	4.50	0.00		0.00	000

CLAIMS ADJUSTED IN THIS CATEGORY: 1 TOTAL BILLED: 717.08 TOTAL PAID 7,170.08

REMITTANCE STATEMENT

AS OF 8/10/90 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT PAGE 14

RA NUMBER 002844812
RA SEQ NUMBER 40

GENERAL HOSPITAL
PROVIDER NUMBER

CLAIM TYPE: INPATIENT SERVICES

MASS ADJUSTMENTS

*** ADJUSTMENT TO CLAIM 9889270860330. ORIGINALLY PAID ON 101389
FOR RECIPIENT DUNN ID RECIP#
PROVIDED 081989-082889 BILLED 7,951.24 PAID 2,475.99
*** NEW CLAIM 90221-302-045

0000000 DUNN I			6090221-302-045	081989-082889	7,951.24	0.00	0.00	2,492.55	343
01 REV CODE	110	MOD	QTY 9	081989-082889	1,620.00	0.00		0.00	343
02 REV CODE	250	MOD	QTY 342	081989-082889	2,545.00	0.00		0.00	343
03 REV CODE	270	MOD	QTY 92	081989-082889	792.34	0.00		0.00	343
04 REV CODE	402	MOD	QTY 1	081989-082889	190.00	0.00		0.00	343
05 REV CODE	410	MOD	QTY 32	081989-082889	2,803.90	0.00		0.00	343
0007002									

REMITTANCE STATEMENT

AS OF 6/02/90 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT PAGE 92

RA NUMBER 002272886
RA SEQ NUMBER 27

GENERAL HOSPITAL
PROVIDER NUMBER

CLAIM TYPE: FINANCIAL ITEMS

* F I N A N C I A L I T E M S *

RECIP NUM	FDOS	REFERENCE ICN	CONTROL NO	TRN DATE	ORIG AMT	BEGIN BAL	APPLIED AMT	NEW BAL
406234734	120189	989076416330	9155752790	060490	4037.56	4037.56	4037.56	
RECOUPMENT - THIS AMOUNT IS WITHHELD FROM YOUR CHECK								
	0000000000000		9069617020	060190	8189.61	8189.61	8189.61	
PAYMENT AMOUNT ADDED TO CLAIMS PAYMENT								

REMITTANCE STATEMENT

AS OF 6/02/90 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT PAGE 98

RA NUMBER 002239547
RA SEQ NUMBER 27

GENERAL HOSPITAL
PROVIDER NUMBER

SUMMARY OF BENEFITS PAID

CLAIMS PAYMENT SUMMARY CHECK NUMBER 3792545

	CLAIMS PAID/DENIED	CLAIMS PD AMT	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
CURRENT PROCESSED	358	526397.28	16337.44	510059.84	8189.61	510059.84
YEAR-TO-DATE-TOTAL	21441	3572901.35	273568.45	3299332.90	0.00	3299332.90

DESCRIPTION OF EXPLANATION CODES LISTED ABOVE

007 TOTAL DAYS DO NOT EQUAL THE DIFFERENCE BETWEEN FROM AND TO DATES.

022 COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS.

025 CLAIM SUBMITTED FOR INFORMATIONAL PURPOSE ONLY. NO PAYMENT IS TO BE MADE.

027 CLAIM DENIED. RESUBMIT AND ADJUSTMENT ON RELATED PAID CLAIM.

PROVIDER INQUIRY FORM

PROVIDER INQUIRY FORM

EDS
P O Box 2009
Frankfort, Ky. 40602

Please remit both copies of the Inquiry Form to EDS.

1 Provider Number
2 Provider Name and Address
3 Rec'd Name (First Last)
4 Medical Assistance Number
5 Billed Amount
6 Claim Service Date
7 RA Date
8 Internal Control Number
9 Provider's Message

10 _____
Signature Date

Dear Provider

____ This claim has been resubmitted for possible payment.
____ EDS can find no record of receipt of this claim. Please resubmit.
____ This claim paid on _____ in the amount of _____
____ We do not understand the nature of your inquiry. Please clarify
____ EDS can find no record of receipt of this claim in the last 12 months.
____ This claim was paid according to Medicaid guidelines.
____ This claim was denied on _____ for EOB code _____

____ Aged claim. Payment may not be made for services over 12 months old without proof that the claim was received by EDS within one year of the date of service; and if the claim rejects, you must show timely receipt by EDS within 12 months of that rejection date. Claims must be received by EDS every 12 months to be considered for payment.

Other _____

EDS Date

ADJUSTMENT REQUEST FORM

MAIL TO: EDS FEDERAL CORPORATION
P.O. BOX 2009
FRANKFORT, KY 40602

ADJUSTMENT REQUEST FORM

1. Original Internal Control Number (I.C.N.)	EDS FEDERAL USE ONLY	
2. Recipient Name	3. Recipient Medicaid Number	
4. Provider Name/Number/Address	5. From Date Service	6. To Date Service
	7. Billed Amt.	8. Paid Amt. 9. R.A. Date

10. Please specify what is to be adjusted on the claim.

11. Please specify REASON for the adjustment request or incorrect original claim payment.

IMPORTANT: THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY OF THE CLAIM AND REMITTANCE ADVICE TO BE ADJUSTED.

12. Signature 13. Date

EDSF USE ONLY---DO NOT WRITE BELOW THIS LINE

Field/Line:
New Data:
Previous Data:

Field/Line:
New Data:
Previous Data:

Other Actions/Remarks:

CODING ADDENDUM

INPATIENT REVENUE CODES

The following is a list of the revenue codes that are accepted by the Medicaid Program when billing for inpatient services on the UB-82 billing form.

INPATIENT REVENUE CODES	DESCRIPTION
100	All Inclusive Room and Board Plus Ancillary
101	All Inclusive Room and Board
110	Private Room-Board, General
111	Medical/Surgical/Gyn
112	OB
113	Pediatric
114	Psychiatric
115	Hospice
116	Detoxification
117	Oncology
118	Rehabilitation
120	Semi-Private Room and Board, General
121	Medical/Surgical/Gyn
122	OB
123	Pediatric
124	Psychiatric
125	Hospice
126	Detoxification
127	Oncology
128	Rehabilitation
130	Semi-Private (3-4 Bed) Room, General
131	Medical/Surgical/Gyn
132	OB
133	Pediatric
134	Psychiatric
135	Hospice
136	Detoxification
137	Oncology
138	Rehabilitation
140	Deluxe Private Room, General
141	Medical/Surgical/Gyn
142	OB
143	Pediatric

CODING ADDENDUM

INPATIENT REVENUE CODES	DESCRIPTION
144	Psychiatric
145	Hospice
146	Detoxification
147	Oncology
148	Rehabilitation
150	Room (Ward), General
1 5 1	Medical/Surgical/Gyn
152	OB
153	Pediatric
154	Psychiatric
155	Hospice
156	Detoxification
157	Oncology
158	Rehabilitation
160	Other Room and Board, General
164	Sterile Environment
170	Nursery, General
171	Newborn
172	Premature
175	NeoNatal ICU
200	Intensive Care Room, General
201	Surgical
202	Medical
203	Pediatric
204	Psychiatric
206	Post ICU
207	Burn Care
208	Trauma
210	Coronary Care Room, General
211	Myocardial Infarction
212	Pulmonary Care
213	Heart Transplant
214	Post-CCU
230	Incremental Nursing, General
231	Nursery
233	
234	CCU
240	All Inclusive Ancillary, General INPATIENT

CODING ADDENDUM

INPATIENT REVENUE CODES	DESCRIPTION
250	Pharmacy, General
251	Generic Drugs
252	Non-Generic Drugs
254	Drugs Incident to other Diagnostic Services
255	Drugs Incident to Radiology
256	Experimental Drugs
257	Non-Prescription
258	IV Solutions
260	IV Therapy, General
261	Infusion Pump
270 ,	Medical/Surgical Supplies, General
271	Non-Sterile Supply
272	Sterile Supply
274	Prosthetic Devices
275	Pace Maker
276	Intraocular Lens
278	Other Implants
280	Oncology, General
300	Laboratory, General
301	Chemistry
302	Immunology
303	Renal Patient (Home)
304	Non-Routine Dialysis
305	Hematology
306	Bacteriology and Microbiology
307	Urology
310	Pathology, General
311	Cytology
312	Histology
314	Biopsy
320	Radiology Diagnostic, General
321	Angiocardiography
322	Arthrography
323	Arteriography
324	Chest X-Ray
330	Radiology-Therapeutic, General
331	Chemotherapy - Injected

CODING ADDENDUM

INPATIENT REVENUE CODES	DESCRIPTION
332	Chemotherapy - Oral
333	Radiation Therapy
335	Chemotherapy - IV
340	Nuclear Medicine, General
341	Diagnostic
342	Therapeutic
350	CT Scan, General
351	Head Scan
352	Body Scan
360	Operating Room, General
361	Minor Surgery
362	Organ Transplant - Other than Kidney
367	Kidney Transplant
370	Anesthesia, General
371	Anesthesia, Incident to Radiology
372	Anesthesia Incident to Other Diagnostic Services
374	Acupuncture
380	Blood, General
381	Packed Red Cells
382	Whole Blood
383	Plasma
384	Platelets
385	Leukocytes
386	Other Components
387	Other Deriatives (Cryopricipitates)
390	Blood Storage and Processing, General
391	Blood Administration
400	Other Imaging Services, General
401	Mammography
402	Ultrasound
403	Screening mammography
410	Respiratory Service General
412	Inhalation Services
413	Hyperbaric Oxygen Therapy
420	Physical Therapy, General
421	Physical Therapy, Visit Charge
422	Physical Therapy, Hourly Charge

CODING ADDENDUM

INPATIENT REVENUE CODES	DESCRIPTION
423	Group Rate
424	Evaluation or Re-Evaluation
440	Speech Therapy, General
441	Visit Charge
442	Hourly Charge
443	Group Rate
444	Evaluation or Re-Evaluation
450	Emergency Room, General (For Services provided prior to June **1, 1991)**
460	Pulmonary Function
470	Audiology, General
472	Treatment
480	Cardiology, General
481	Cardiac Cath Lab
482	Stress Test
610	MRI, General
611	Brain (including Brainstem)
612	Spinal Cord (including Spine)
'621	Supplies Incident to Radiology
622	Supplies Incident to other Diagnostic Services
634	Erythropoietin (EPO) Less than 10,000 Units
635	Erythropoietin (EPO) 10,000 or More Units
636	Erythropoietin (EPO) Drug Requiring Detailed Coding
700	Cast Room, General
710	Recovery Room, General
720	Labor/Delivery Room, General
721	Labor
722	Delivery
723	Circumcision
724	Birthing Center (For services provided prior to June 1, 1991).
730	EKG/ECG, General
731	Holter Monitor
732	Telemetry (Includes fetal monitoring)
740	EEG, General
750	Gastro-Intestinal Services, General
760	Observation Room, General (For services provided prior to June 1, 1991).

CODING ADDENDUM

INPATIENT REVENUE CODES	DESCRIPTION
790	Lithotripsy, General
800	Inpatient Renal Dialysis, General
801	Inpatient Hemodialysis
802	Inpatient Peritoneal (NON-CAPD)
803	Inpatient Continuous/Ambulatory Peritoneal Dialysis (CAPD)
804	Inpatient Continuous/Cycling Peritoneal Dialysis (CCPD)
810	Organ Acquisition, General
811	Living Donor
812	Cadaver Donor
813	Unknown Donor
814	Other Kidney Acquisition
815	Cadaver Donor - Heart
816	Other Heart Acquisition
817	Donor - Liver
880	Miscellaneous Dialysis, General
881	Ultrafiltration
890	Donor Bank, General
891	Bone
892	Organ (Other than Kidney)
893	Skin
900	Psychiatric/Psychological Treatments, General
901	Electroshock Treatment
920	Other Diagnostic Services, General
921	Peripheral Vascular Lab
922	Electromyelogram
923	Pap Smear
924	Allergy Test
925	Pregnancy Test
940	Other Therapeutic Services, General
943	Cardiac Rehabilitation
963	Anesthesiologist (MD)
971	Pathologist (M.D.)
972	Radiologist - Diagnostic (M.D.)
973	Radiologist - Therapeutic (M.D.)
974	Radiologist - Nuclear Medicine (M.D.)

985	Cardiologist - EKG (M.D.)
986	Cardiologist - EEG (M.D.)
997	Admission Kits
001	Total Charges

The following ICU/CCU Incremental Nursing Revenue Codes listed in Column A cannot be reimbursed by the Medicaid Program unless they are billed in conjunction with the appropriate accommodation revenue codes in Column B:

A		B
230,231	CAN ONLY BE REIMBURSED IN CONJUNCTION WITH	170-175
230,233	CAN ONLY BE REIMBURSED IN CONJUNCTION WITH	200-208
230,234	CAN ONLY BE REIMBURSED IN CONJUNCTION WITH	210-214

Each hospital has a choice in determining the type of billing to utilize when billing for services provided to their recipients. The facility shall be consistent in their billing procedures for all payors. Use the following guideline to determine the appropriate procedure.

1. If billing detailed charges, enter accommodation revenue codes 110-219 plus appropriate revenue codes for all covered ancillary and professional services and revenue code 001 for total charges.

2. If billing an all inclusive accommodation (revenue code 100), which includes ancillary services, do not include any other revenue codes except those codes representing professional services and revenue code 001 for total charges.

3. If billing an all inclusive accommodation revenue code 101, the facility is permitted to include regular ancillary charges plus professional services and revenue code 001 for total charges.

4. If billing an all inclusive accommodation revenue code 101 plus all inclusive ancillary revenue code 240 do not include any other charges except those codes representing professional services and revenue code 001 for total charges.

5. If billing for regular accommodation revenue codes 110-219 plus all inclusive ancillary revenue code 240, do not include any other codes except those for professional services and revenue code 001 for total charges.

CODING ADDENDUM

INPATIENT AND OUTPATIENT PROFESSIONAL COMPONENT

The following revenue codes (Column A) are professional component revenue codes that cannot be reimbursed by the Medicaid Program unless they are billed in conjunction with the revenue codes in column B.

A		B
963	CAN ONLY BE REIMBURSED IN CONJUNCTION WITH	370 or 374
971	CAN ONLY BE REIMBURSED IN CONJUNCTION WITH	300 through 307, 310 through 312 314 or 460
972	CAN ONLY BE REIMBURSED IN CONJUNCTION WITH	320 through 324 350 through 352 400 through 402 610 through 612 750, 790 and 920 through 925
973	CAN ONLY BE REIMBURSED IN CONJUNCTION WITH	330, 331, 332, 333 Or 335
974	CAN ONLY BE REIMBURSED IN CONJUNCTION WITH	340 through 342 350 through 352
985	CAN ONLY BE REIMBURSED IN CONJUNCTION WITH	480 through 482, 730, 731 or 943
986	CAN ONLY BE REIMBURSED IN CONJUNCTION WITH	320, 740

*Revenue code 981 is payable only on an outpatient type of bill (131).

CODING ADDENDUM

OUTPATIENT REVENUE CODES

The following is a list of the revenue codes that are reimbursable by the Medicaid Program when billing for outpatient services on the UB-82 billing form.

OUTPATIENT REVENUE CODES	DESCRIPTION
250	Pharmacy, General
251	Drugs/Generic
252	Drugs/Non-Generic
254	Drugs Incident to Diagnostic Services
255	Drugs Incident to-Radiology
258	IV solution
260	IV Therapy, General
261	IV Therapy, Infusion Pump
270	Med/Surg Supplies/Devices
272	Sterile Supplies
275	Pace Maker
276	Intraocular Lens
278	Other Implants
280	Oncology
300	Lab, General
301	Chemistry
302	Immunology
303	Renal
304	Non-Routine Dialysis
305	Hematology
306	Bacteriology/Microbiology
307	Urology
310	Lab, Pathology
311	Cytology
312	Histology
314	Biopsy
320	Radiology, Diagnostic
321	Angiocardiography
322	Arthrography
323	Arteriography
324	Chest X-Ray
330	Radiology, Therapeutic

CODING ADDENDUM

OUTPATIENT REVENUE CODES	DESCRIPTION
331	Chemotherapy, Injected
332	Chemotherapy, Oral
333	Radiation Therapy
335	Chemotherapy - IV
340	Nuclear Medicine, General
341	Nuclear Medicine, Diagnostic
342	Nuclear Medicine, Therapeutic
350	CT Scan, General
351	CT Scan, Head Scan
352	CT Scan, Body Scan
360	Operating Room, Service General
361	Operating Room, Minor Surgery
370	Anesthesia, General
371	Anesthesia Incident to Radiology
372	Anesthesia Incident to other Diagnostic Services
374	Anesthesia, Acupuncture
380	Blood, General
381	Packed Red Cells
382	Whole Blood
383	Plasma
384	Platelets
385	Leucocytes
386	Blood, Other Components
387	Blood, Other Derivatives (Cryopricipitates)
390	Blood Storage and Processing
391	Blood Administration
400	Other Imaging Service General
401	Mammography
402	Ultra Sound
403	Screening Mammography
410	Respiratory Service General
412	Inhalation Service
413	Hyperbaric Service
420	Physical Therapy, General
421	Physical Therapy, Visit Charge
422	Physical Therapy, Hourly Charge
423	Physical Therapy, Group Rate

CODING ADDENDUM

OUTPATIENT REVENUE CODES	DESCRIPTION
424	Physical Therapy, Evaluation or Re-Evaluation
440	Speech-Language Pathology, General
441	Speech-Language Path. - Visit Charge
442	Speech-Language Path. - Hourly Charge
443	Speech-Language Path. - Group Rates
444	Speech-Language Path. - Evaluation or Re-Evaluation
450	Emergency Room
460	Pulmonary Function
470	Audiology, General
471	Audiology, Diagnostic
472	Audiology, Treatment
480	Cardiology, General
481	Cardic Cath, Lab
482	Stress Test
510	Clinic, General
512	Dental Clinic
610	MRI, General (Effective Date 11/25/85)
611	MRI, Brain (Effective Date 11/25/85)
612	MRI, Spine (Effective Date 11/25/85)
621	Supplies Incident to Radiology
622	Supplies Incident to Other Diagnostic Services
634	Erythropoietin (EPO) Less Than 10,000 Units
635	Erythropoietin (EPO) 10,000 or more Units
636	Erythropoietin (EPO) Drug Requiring Detailed Coding
700	Cast Room
710	Recovery Room
720	Labor Room/Delivery, General
721	Labor Room
722	Delivery Room
723	Circumcision
724	Birthing Center
730	EKG/ECG (Electrocardiogram), General
731	Holter Monitor
732	Telemetry (Incl Fetal Monitoring)
740	EEG (Electrocencephalogram), General
750	Gastro-Intestinal Service General

CODING ADDENDUM

OUTPATIENT REVENUE CODES	DESCRIPTION
760	Observation/Treatment Room
790	Lithotripsy, General
817	Liver Acquisition
820	Hemodialysis, General
821	Hemodialysis/Composite or Other Rate
830	Peritoneal Dialysis, General
831	Peritoneal, Composite Rate or Other Rate
840	Continuous CAPD, General
841	CAPD/Composite or Other Rate
845	CAPD Support Services
850	Continuous Cycling Peritoneal Dialysis (CCPD) - General
851	CCPD/Composite *or* Other Rate
880	Miscellaneous Dialysis, General
881	Ultrafiltration
891	Donor Bank, Bone
892	Donor Bank, Organ (Other than Kidney)
893	Donor Bank, Skin
901	Electroshock Treatment
920	Other Diagnostic Services
921	Peripheral Vascular Lab
922	Electromyelogram
923	Pap Smear
924	Allergy Test
925	Pregnancy Test
940	Other Therapeutic Service
943	Cardiac Rehabilitation
963	Anesthesiologist (M.D.)
971	Pathologist (M.D.)
972	Radiologist - Diagnostic (M.D.)
973	Radiologist - Therapeutic (M.D.)
974	Radiologist - Nuclear Medicine (M.D.)
981	E.R. Professional Fee
985	Cardiologist - EKG (M.D.)
986	Cardiologist - EEG (M.D.)
001	Total Charges

CODING ADDENDUM

OUTPATIENT DRUGS

The following biological and blood constituents are the only drugs payable on an outpatient basis for services provided prior to July 1, 1990.

REVENUE CODE	BIOLOGICAL AND BLOOD CONSTITUENTS
387	Rho (D) Immune Globulin (Human)
387	Anti-hemophilic factor (AHF)
270	Rabies Drug Treatment
331	Chemotherapy for any blood or chemical dyscrasia (e.g. cancer, hemophilia)
303	Medications associated with renal dialysis treatment
258	Base IV solutions (without drug additives)
270	Tetanus toxoid
270	Cortisone Injections

NOTE: For services provided on or after July 1, 1990, the Medicaid Program reimbursement is available for drugs (Revenue Codes 250-252) administered in the outpatient department. Reimbursement is not available for take home drugs or drugs which have been deemed less-than-effective by the Food and Drug Administration (FDA).

CASH REFUND DOCUMENTATION

MAIL TO: EDS
P.O. BOX 2009
FRANKFORT, KY 40602

CASH REFUND DOCUMENTATION

1. Check Number	2. Check Amount
3. Provider Name/Number/Address	4. Recipient Name
	5. Recipient Number
6. From Date of Service	7. To Date of Service / 8. RA Date

9. Internal Control Number (If several ICNs attach RAs)

_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Reason for Refund: (Check appropriate blank)

__ a. Payment from other source - Check the category and list name (attach a copy of EOB)
__ Health Insurance
__ Auto Insurance
__ Medicare paid
__ Other _____

__ b. Billed in error

__ c. Duplicate payment (attach a copy of both RA's)
If RA's are paid to 2 different providers specify to which provider number the check is to be applied.

__ d. Processing error OR Overpayment

Explain why _____

__ e. Paid to wrong provider

__ f. Money has been requested - date of the letter __/__/__
(Attach a copy of letter requesting money)

__ g. Other _____

Contact Name _____ Phone: _____

ADVANCE DIRECTIVE LAW

DESCRIPTION OF KENTUCKY

ADVANCE DIRECTIVE LAW

In compliance with the mandate for Kentucky to develop a written description of its statutory and case law concerning advance directives, this office presents such a description below, which is based on statutory law, there being no case law which has specifically addressed the issue.

KENTUCKY LAW ON ADVANCE DIRECTIVES FOR MEDICAL DECISIONS

THE KENTUCKY LIVING WILL ACT

The 1990 session of the Kentucky General Assembly passed andthe Governor signed into law House Bill No 113, known as the Kentucky Living Will Act, which is codified at KRS311.622-644 and now sanctions the right of adult Kentuckians of sound mind to execute a written declaration which would allow life-prolonging treatments to be withheld or withdrawn in the event they become terminally ill and can no longer participate in making decisions about their medical care. The living will must be signed by the declarant in the presence of two subscribing witnesses who must not be blood relatives who would be beneficiaries of the declarant, beneficiaries of the declarant under the descent and distribution statutes of Kentucky, an employee of a health care facility in which the declarant is a patient, an attending physician of the declarant, or any person directly financially responsible for the declarant's health care. The living will must be notarized.

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Two physicians, one of whom being the patient's attending physician, would have to certify that the declarant's condition was terminal before the living will could be implemented. The living will would not allow for the withholding or withdrawal of food or water, or medication or medical procedures deemed necessary to alleviate pain, and it would not apply to pregnant women.

THE HEALTH CARE SURROGATE ACT OF KENTUCKY

Also enacted into law by the 1990 session of the Kentucky General Assembly and the Governor was Senate Bill No. 88, the Health Care Surrogate Act of Kentucky, which is codified at KRS 311.970-986 and allows an adult of sound mind to make a written declaration which would designate one or more adult persons who could consent or withdraw consent for any medical procedure or treatment relating to the grantor when the grantor no longer has the capacity to make such decisions. This law requires that the grantor, being the person making the designation, sign and date the designation of health care surrogate which, at his option, may be in the presence of two adult witnesses who also sign or he may acknowledge his designation before a notary public without witnesses. The health care surrogate cannot be an employee, owner, director or officer of a health care facility where the grantor is a resident or patient unless related to the grantor:

Except in limited situations, a health care facility would remain obligated to provide food and water, treatment for the relief of pain, and life sustaining treatment to pregnant women, notwithstanding the decision of the patient's health care surrogate.

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ADVANCE DIRECTIVE LAW

DURABLE POWER OF ATTORNEY

A person may execute, pursuant to KRS 386.093, a document known as a durable power of attorney which would allow someone else to be designated to make decisions regarding health, personal, and financial affairs notwithstanding the later disability or incapacity of the person who executed the durable power of attorney.

PREPARED BY:

THE CABINET FOR HUMAN RESOURCES
OFFICE OF GENERAL COUNSEL
APRIL 22.1991

-3-

Living Will Declaration

Declaration made this _____ day of _____(month), _____ (year).
I, _____, willfully and voluntarily make known my desire that my dying all not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have a terminal condition and my attending and one (1) other physician in their discretion, have determined such condition is incurable and irreversible and will result in death within a relatively short time, and where the application of life-prolonging treatment would serve only to artificially prolong the dying process, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain or for nutrition or hydration.

In the absence of my ability to give directions regarding the use of such life-prolonging treatment, it is my intention that this declaration shall be honored by my attending physician and my family as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

State of Kentucky)
)Sct.
County of _____)

Before me, the undersigned authority, on this day personally appeared _____, _____, Living Will Declarant, and _____ and _____, known to me to be witnesses whose names are each signed to the foregoing instrument, and all these persons being first duly sworn, _____, Living Will Declarant, declared to me and to the witnesses in my presence that the instrument is the Living Will Declaration of the declarant and that the declarant has willingly signed and that such declarant executed it as a free and voluntary act for the purposes therein expressed: and each of the witnesses stated to me, in the presence and hearing of the Living Will Declarant, that the declarant signed the declaration as witnessed, and to the best of such witnesses' knowledge, the Living Will Declarant was eighteen(18) years of age or over, of sound mind and under no constraint or undue influence.

_____ Living Will Declarant

_____ Witness

_____ Address

_____ Witness

_____ Address

Subscribed, sworn to and acknowledged before me by _____, Living Will Declarant, and subscribed and sworn before me by _____ and _____, witnesses, on this the _____(day) of _____(month)_____(year).

_____ Notary Public State at Large

_____ Date my commission expires

ADVANCE DIRECTIVE LAW

DESIGNATION OF HEALTH CARE SURROGATE

I DESIGNATE _____ AS MY HEALTH CARE SURROGATE(S) TO MAKE ANY HEALTH CARE DECISIONS FOR ME WHEN I NO LONGER HAVE DECISIONAL CAPACITY. IF _____ REFUSES OR IS NOT ABLE TO ACT FOR ME, I DESIGNATE _____ AS MY HEALTH CARE SURROGATE(S).

ANY PRIOR DESIGNATION IS REVOKED.

SIGHED THIS _____ DAY OF _____, 19_____

_____
SIGNATURE AND ADDRESS OF THE GRANTOR

IN OUR JOINT PRESENCE, THE GRANTOR, WHO IS OF SOUND MIND AND EIGHTEEN YEARS OF AGE, OR OLDER, VOLUNTARILY DATED AND SIGNED THIS WRITING OR DIRECTED IT TO BE DATED AND SIGNED FOR THE GRANTOR.

_____
SIGNATURE AND ADDRESS OF WITNESS

_____
SIGNATURE AND ADDRESS OF WITNESS

COMMONWEALTH OF KENTUCKY

_____ COUNTY

BEFORE ME, THE UNDERSIGNED AUTHORITY, CAME THE GRANTOR WHO IS OF SOUND MIND AND EIGHTEEN (18) YEARS OF AGE, OR OLDER, AND ACKNOWLEDGED THAT HE VOLUNTARILY DATED AND SIGNED THIS WRITING OR DIRECTED IT TO BE SIGNED AND DATED AS ABOVE.

DONE THIS _____ DAY OF _____, 19_____

_____
SIGNATURE OF NOTARY PUBLIC

DATE COMMISSION EXPIRES: _____

ADVANCE DIRECTIVE LAW

ADVANCE DIRECTIVE

ACKNOWLEDGMENT

NAME: _____ **DATE Of BIRTH:** _____

SOC. SEC.#: _____

PLEASE READ THE FOLLOWING FIVE STATEMENTS:

Place your Initials after each statement.

1. I have been given written materials about my right to accept or refuse medical treatment. (Initialed)
2. I have been informed of my right to formulate advance directives. _____(Initialed)
3. I undentand that I am not required to have an advance directive in order to receive medical treatment. _____(Initialed)
4. I understand that the terms of any advance directive that I have executed will be followed by my caregivers to the extent permrtted by law. _____(Initialed)
5. I understand that I can change my mind at any time and that my decision will not result in the withholding of any benefits or medical services. _____(Initialed)

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ I HAVE EXECUTED AN ADVANCE DIRECTIVE.

☐ I HAVE NOT EXECUTED AN ADVANCE DIRECTIVE.

_____ DATE: _____
Patient/Guardian

_____ DATE: _____
Health Care Provider Representative

ADVANCE DIRECTIVE LAW

PATIENT SELF-DETERMINATION PROTOCOL FOR CERTIFIED HEALTH CARE PROVIDERS

1. The Certified Health Care Provider shall inform all adult patients, in writing and orally, of information under Kentucky Law concerning their right to make decisions relative to their medical care.

2. The Certified Health Care Provider shall present each adult patient with a written copy of the agency's policy concerning implementation of their rights.

3. The Certified Health Care Provider shall not condition the provision of care or otherwise discriminate against any patient based on whether the patient has executed an advance directive.

4. The Certified Health Care Provider shall document in the patient's medical record whether or not the patient has executed an advance directive.

5. The Certified Health Care Provider shall ensure compliance with requirements of Kentucky Law concerning advance directives.

6. The Certified Health Care Provider shall educate all agency staff and the general public concerning advance directives.

ADVANCE DIRECTIVE LAW

PATIENT SELF-DETERMINATION

Policy:

Advise all adult patients (a person eighteen [18] years of age or older and who is of sound mind) of their rights concerning advance directives. (According to provider type, i.e., admission, start of care, etc.)

Puroose:

1. To assure individuals understand they have the right to:

a. Accept or refuse medical or surgical treatment; and

b. Formulate advance directives.

Procedure:

Each Certified Health Care Provider shall:

1. Desi nate a person or persons responsible for informing adult patients of their rig6t to make decisions concerning their medical care.

2. Distribute to each adult patient the following information:

a. The Cabinet for Human Resources' description of Kentucky Laws on Advance Directives.

b. Agency policy regarding implementation of advance directives.

NOTE: Recommend distribution of additional information to assist patients and/or staff in understanding advance directives. The following materials are acceptable:

'Advance Directives Issues and Answers'
Hospice of the Bluegrass

'Advance Directives, living Will, Health Care Surrogate, Durable Power of Attorney-Video
Hospice of the Bluegrass

'About Advance Medical Directives'
Channing Bete Co., Inc.

'Living Will'
Division of Aging Services

ADVANCE DIRECTIVE LAW

PATIENT SELF-DETERMINATION (Continued)

'Planning for Difficult Times-Tomorrow's Choicer'
'Planning For Difficult Times -A Matter of Choice'
American Association of Retired Persons

3. Maintain *Living Will* **and** *Designation of Health* **Care** *Surrogate* **documents for distribution to adult patients upon request.**

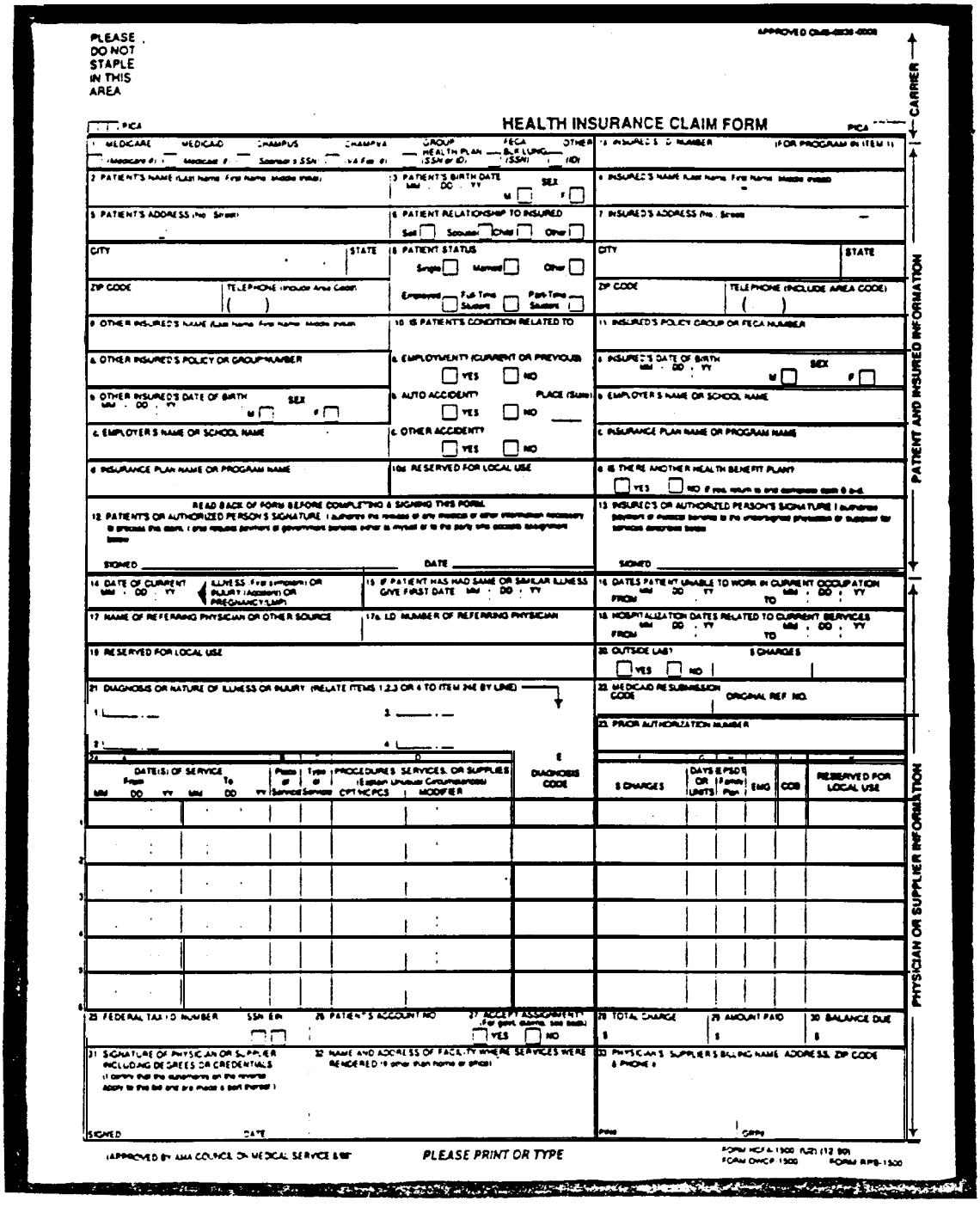
4. Documentation supporting compliance with the requirements regarding non-discriminatory care shall be incorporated into the Quality Assurance process.

5. Documentation supporting the patient's decision to formulate an advance directive shall be included in the medical record. (Recommend *use* **of attached Advance** *Directive Acknowledgment* **Form.) A process shall be developed to assure appropriate staff are advised of the patient'sdirective.**

6. Documentation supporting all aspects of the staff and general public education campaign shall be recorded by appropriate personnel.

7. **Stipulate by policy. family members or guardians will be provided with information regarding advance directives when the patient is comatose or otherwise incapacitated and unable to receive the information. Once he or she is no longer incapacitated the information must be provided directly to the adult patient.**

HEALTH INSURANCE CLAIM FORM (HCFA-1500 Rev. 12/90)



PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/87)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500
FORM RRB-1500

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HOSPITAL SERVICES MANUAL APPENDIX

SECTION I - INTRODUCTION

I. INTRODUCTION

A. Introduction

This edition of the Kentucky Medicaid[~~Medical Assistance~~] Program Hospital Services Manual has been formulated with the intention of providing you, the provider, with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid[~~Medical Assistance~~] Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will assist you in understanding what procedures are reimbursable and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.26 might be replaced by new pages 7.26 and 7.27).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning agency policy shall be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services shall be directed to the Division of Program Services, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-7759. Questions concerning billing procedures or the specific status of claims shall be directed to EDS, P.O. Box 2009, Frankfort, Kentucky 40602, or Phone (800) 756-7557 [~~333-2100~~] or (502) 227-2525.

SECTION II - KENTUCKY MEDICAIO PROGRAM

II. KENTUCKY MEDICAID PROGRAM

A. General

The Kentucky Medicaid Program [~~, frequently referred to as the Medicaid Program,~~] is administered by the Cabinet for Human Resources, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U. S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services provided to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medicaid [~~Medical Assistance~~] Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that the Department for Medicaid Services is bound by both Federal and State statutes and regulations governing the administration of the State Plan. The Department cannot reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered, unallowable medical services.

The Kentucky Medicaid Program, Title XIX, Medicaid, is not to be confused with Medicare. Medicare is a Federal program, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. [~~The~~] Coverage, [~~either by Medicare or Medicaid,~~] will be specified in the body of this manual in Section IV.

B. Administrative Structure

The Department for Medicaid Services within the Cabinet for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes.of benefits, and basis for reimbursement for the medical care aspects of the Program. The Department for Medicaid Services makes the actual payments to the providers of medical services, who have submitted claims for services within the scope of covered benefits which have been provided to eligible recipients.

Determination of the eligibility status of individuals and families for Medical Assistance benefits is a responsibility of the local Department for Social Insurance offices, located in each county of the state.

C. Advisory Council

The Kentucky Medicaid Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of eighteen (18) ~~[seventeen]~~ members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining seventeen (17) ~~[sixteen]~~ members are appointed by the Governor to four-year terms. Ten (10) ~~[Nine]~~ members represent the various professional groups providing services to Program recipients, and are appointed from a list of three (3) nominees submitted by the applicable professional associations. The other seven (7) members are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three (3)months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five (5) or six (6) member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees is decided by the professional organization that the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

D. Policy

The basic objective of the Kentucky Medicaid Program is to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulate that Title XIX Programs have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medicaid Program is payor of last resort. Accordingly, the provider of service shall seek reimbursement from third party groups for medical services provided. If you, as the provider, receive payment from the Medicaid Program before knowing of the third party's liability, a refund of that payment amount shall be made to the Medicaid Program, as the amount payable by the Department shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap, or age.

Each medical professional is given the choice of whether or not to participate in the Medicaid Program. From those professionals who have chosen to participate, recipients may choose the one from whom they wish to receive their medical care.

When the Department makes payment for a covered service and the provider accepts the payment made by the Medicaid Program in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient.

Providers of medical service attest by their signatures (not facsimilies) that the presented claims are valid and in good faith. The submission of fraudulent claims is punishable by fine or imprisonment.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky.

The provider's adherence to the application of policies in this manual is monitored through either post-payment review of claims by the Department, or computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual remains in effect and thus the claims become subject to post-payment review by the Department.

Medical records and any other information regarding payments claimed shall be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection or copying by Cabinet personnel. Records shall be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit exception or other dispute.

All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services to recipients of this Program shall be on a level of care at least equal to that extended private patients, and normally expected of a person serving the public in a professional capacity.

All recipients of this Program are entitled to the same level of confidentiality accorded patients NOT eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical speciality.

All services are reviewed for recipient and provider abuse. Willful abuse by providers can result in their suspension from Program participation. Abuse by recipients may result in surveil lance of the payable services they receive.

Claims shall not be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, claims shall not be paid for services that required, but did not have, prior authorization.

Claims shall not be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall attach to the Cabinet and no bill for the same service shall be paid by the Cabinet.

E. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment or any part thereof to a use other than for the use and benefit or such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years of both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a

State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly- or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(C) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(D) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

F. Timely Submission of Claims

Claims for covered services provided to eligible Title XIX recipients shall be received by the Medicaid Program within twelve (12) months from the date of service in order to be reimbursed. Claims received after that date will not be payable. This policy became effective August 23, 1979.

According to Federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months of the Medicare adjudication date. Federal regulations define "Timely submission of claims" as received by Medicaid "no later than 12 months from the date of service." Received is defined in 42 CFR 447.45 [~~445.45~~] (d) (5) as follows: "The date of receipt is the date the agency received the claim as indicated by its date stamp on the claim." For Kentucky, the date received is included within the Internal Control Number (ICN) which is assigned to each claim as it is received at EDS. The third through the seventh digits of the ICN (e.g. 9889043450010 = February 12, 1989) identify the year and day of receipt, in that order. The day is represented by a Julian date which counts the days of the year sequentially (January 1 = 001 through December 31 - 365/366). To consider those claims 12 months past the service date for processing,

the provider shall attach documentation showing timely RECEIPT by EDS and documentation showing subsequent billing efforts. Claim copies are not acceptable documentation of timely billing. A maximum of twelve (12) months can elapse between EACH RECEIPT of the aged claim by the Program.

Claims for Title XVIII deductible and coinsurance amounts can be processed after the twelve-month time frame if they are received by the Medicaid Program within six (6) months of the Medicare disposition.

G. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which, as an adjunct to the Kentucky Medicaid Program, provides certain categories of medical recipients with a primary physician or family doctor. Only those Medicaid recipients who receive medical assistance under the Aid to Families with Dependent Children (AFDC), or AFDC-related categories are covered by KenPAC. Specifically excluded are: the aged, blind, and disabled categories of recipients; nursing facilities, intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD); and mental hospital inpatients; foster care cases; [~~refugee cases;~~] all spend-down cases; and all Lock-In cases. To aid in distinguishing from regular Medicaid Program recipients, the KenPAC recipients will have a green Medicaid Program card with the name, address, and telephone number of their primary care provider.

Primary physician specialists or groups who can participate as primary physicians are:

General Practitioners	Obstetricians	Primary Physician Clinics
Family Practitioners	Gynecologists	Primary Care Centers
Pediatricians	Internists	Rural Health Clinics

Recipients can select a primary physician or clinic who agrees to participate in Medicaid and KenPAC. Recipients not selecting a primary physician will be assigned one within their home county. A primary physician can serve up to 1,500 patients for each full-time equivalent physician. Primary Care Centers and Rural Health Clinics can also be assigned recipients based on the number of Registered Nurse Practitioners they have on staff.

KenPAC primary physicians or clinics shall arrange for physician coverage 24 hours per day, seven days per week. A single 24 hour access telephone number shall be provided by the primary physician or clinic. This number will be printed on the recipient's KenPAC Medical Assistance Identification Card.

The following service categories shall be either provided by the primary physician or clinic or referred by the primary physician or clinic in order to be reimbursed by the Medicaid Program.

Physician (excludes Ophthalmologists, Psychiatrists, obstetrical services and routine newborn care billed using the mother's MAID number)
Hospital Inpatient and Outpatient (excluding psychiatric admissions and routine newborn care billed using the mother's MAID number)
Laboratory Services
Nurse Anesthetists
Rural Health Clinic Services
Home Health
Primary Care Centers
Ambulatory Surgical Centers
Durable Medical Equipment
Advanced Registered Nurse Practitioners

Services not included in the above list can be obtained by the KenPAC recipient in the usual manner.

Referrals can be made by the KenPAC primary physician or clinic to another provider for specialty care or for primary care during his or her absence. Special authorization or referral form is not required and referrals shall occur in accordance with accepted practices in the medical community. To ensure that payment will be made, the primary physician or clinic shall provide the specialist or other physician with his or her Medicaid Program provider number, which is to be entered on the billing form to signify that the service has been authorized. With the primary care physician's approval, his or her provider number can be relayed by a referred specialist or institution to other specialists or institutions.

Claims for services provided to KenPAC recipients which do not have a referral from their primary physician shall[~~will~~] not be paid by the Medicaid Program.

"Emergency Care" is defined as a condition for which a delay in treatment can result in death or permanent impairment of health.

Pre-authorization from the primary physician is not required for emergency care. The primary physician shall be contacted, whenever practical, to be advised that care has been provided, and to obtain the physician's authorization number. If the authorization cannot be obtained from the primary physician, the provider shall contact the KenPAC Program to obtain an authorization number before submitting a claim.

"Urgent care" is defined as a condition not likely to cause death or lasting harm, but for which treatment shall not wait for a normally scheduled appointment (e.g., suturing minor cuts, setting simple broken bones, treating dislocated bones, and treating conditions characterized by abnormally high temperatures).

The primary physician shall be contacted for prior authorization of urgent care. If prior authorization is refused, any service provided to the client shall[~~is~~] not be payable by the Kentucky Medicaid Program. If the recipient's primary physician cannot be reached for prior authorization, urgent care is to be provided and the necessary authorization secured after the service is provided. Under this circumstance, if post-authorization is refused by the primary physician or the primary physician cannot be contacted after service has been provided, special authorization can be obtained from the KenPAC Program. When the Program determines that the special authorization procedure is being misused, the individual provider will be advised that special authorization for further services can be refused.

Routine care in the emergency room is not to be authorized by the primary physician, and shall[~~will~~] not be payable under the Program; however, the primary care physician may authorize a brief examination in the emergency room in order to determine if an urgent care situation exists, even if the patient is subsequently determined as a result of the examination to require only routine care.

KenPAC primary physicians and clinics, in addition to their normal fee for service reimbursements from Medicaid, will be paid $3.00 per month for each KenPAC patient they manage. Maximum monthly reimbursement shall[~~can~~] not exceed $3,000.00 per physician. Any questions about the KenPAC Program shall be referred to:

KenPAC Branch
Division of Patient Access and Assessment
Department for Medicaid Services
275 East Main Street, Third Floor East
Frankfort, KY 40621

Information and special authorization numbers can be obtained by calling toll free 1-800-635-2570 (In-State) or 1-502-564-5198 (In- or Out-of-State).

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

A. Appropriate Certification

1. Acute care hospitals shall be licensed by the state and certified for participation under Title XVIII of Public Law 89-97 (Medicare) in order to be eligible to submit a Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services Provider Agreement (MAP-343 Rev. 5/86), Department for Medicaid Services Certification on Lobbying (MAP-343A), and Department for Medicaid Services Provider Information Form MAP-344 (Rev. 03/91) to the Medicaid Program. Hospitals participating in the Kentucky Medicaid Program are required to meet the current conditions of participation for hospitals, HIR-10 (Rev. 6/67) governing participation under Title XVIII of Public Law 89-97, and amendments thereto. In those instances where higher standards are set by the Medicaid Program, these higher standards will also apply.

   An applicant shall not bill the Medicaid Program for services provided to eligible recipients prior to the assignment by the Medicaid Program of a provider number. The Medicaid Program will not assign a provider number until all forms required for the application for participation are completed by the applicant and returned to the Department for Medicaid Services and it is determined that the applicant is eligible to participate. Once an applicant is notified in writing of an assigned provider number, the Medicaid Program can be billed for covered services provided to eligible recipients.

2. Certification for participation under Title XVIII will not be required of hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

3. Any hospital wishing to terminate its agreement shall submit this in writing to the office of the Commissioner, Department for Medicaid Services. Any services provided to recipients by the hospital as of the date of that hospital's termination will not be reimbursable by the Medicaid Program.

4. If a provider wishes to submit EMC claims, the provider shall complete and submit a Provider Agreement Addendum (MAP-380 Rev. 4/90). If a third party computer billing agency is used to prepare the media for the provider, the electronic media billing agency shall also complete and submit an Agreement (MAP-246 Rev. 10/86). These completed forms shall be mailed directly to the Department for Medicaid Services, Provider Enrollment, 275 East Main Street, Frankfort, Kentucky 40621.

5. The Department for Medicaid Services has authorized payment for services provided July 1, 1987, and after to eligible Medicaid recipients in Medicaid-certified dual-licensed beds, in accordance with KRS 2168.107. Please refer to your Nursing Facility Services Manual ~~[Intermediate Care Facility Manual or Skilled Nursing Facility Manual]~~ for detailed information.

6. If a provider wishes to bill the Medicaid Program for hospital-based physicians, the hospital shall complete the Certification of Conditions Met (MAP-346) and the Statement of Authorization (MAP-347). The MAP-347 shall be completed and retained in the hospital's files and the MAP-346 shall be completed and submitted to the Medicaid Program prior to billing for any physician services. Without the completion of these forms, a hospital will be submitting fraudulent claims.

   This same procedure wi 11 also apply to all hospital providers that are billing the Medicaid Program for physical therapy and speech therapy services.

B. Out-of-State Hospitals

Out-of-state hospitals can automatically participate in the Medicaid Program if they are participating in their own state's Title XIX program. They shall forward to the Medicaid Program a completed Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services Provider Agreement (MAP-343) and Provider Information form (MAP-344). If they do not participate in their own state's Title XIX Program, they shall be certified to participate in the Title XVIII Program. They shall then forward a completed MAP-343 and MAP-344 to the Medicaid Program.

Out-of-state hospitals shall also provide to the Medicaid Program a current notice of continuing certification of participation in their state's Title XIX Program. If not, Kentucky Medicaid participation shall be terminated in accordance with the expiration date of the original participation agreement.

Out-of-state hospitals on binding review with a Medicaid Peer Review Organization (PRO) in their state shall review all Kentucky Medicaid admissions for medical necessity before payment can be made. All bills submitted for payment by hospitals on binding review shall verify this by completing form locator 87 on the UB-82 claim form.

Hospitals not on binding review with a Medicaid PRO are to perform utilization review in accordance with their state's utilization review guidelines. Verification that the utilization review mechanism of the hospital reviewed the admission will be accomplished by completing form locator 87 on the UB-82 claim form.

Hospitals will be required to submit additional information if requested by the Program.

C. Out-of-Country Hospitals

Hospitals located outside the United States and Territories cannot participate in the Kentucky Medicaid [Medical Assistance] Program.

D. Peer Review Organization (PRO)

The Professional [Review] Standards Review Organization (PSRO) was established in 1972 by Public Law 92-603 and later changed to Peer Review Organization (PRO). The primary purpose of the PRO is to assure that services provided to Title XIX recipients are medically necessary and at the appropriate level of care.

Emergency admissions do not require pre-admission review but admission review is to be performed within two (2) working days of said admissions. The authorized length of stay (LOS) will be determined, for these types of admission, during admission review.

Scheduled admissions require pre-admission review which shall be obtained by the office staff of the admitting physician. The pre-authorization number and length of stay (LOS) assigned by the PRO shall be provided to the hospital by the admitting physician.

If the recipient received a backdated Medical Assistance Identification Card showing retroactive eligibility, the hospital staff can call the PRO for review of the service. This needs to be completed immediately after the card is received by the recipient.

LOS extension requests shall be initiated by hospital staff by contacting the PRO staff at the toll-free number.

The PRO office can be contacted at 1-800-292-2392 In-state or 1-800-228-5762 (In or Out-of-State) between the hours of 8:00 a.m. and 5:30 p.m. (Eastern Standard Time on Monday through Friday).

Address inquiries regarding PRO procedures to:

Healthcare Review Corporation
9200 Shelbyville Road
Suite 215
Louisville, KY 40222

E. Termination of Participation

If a provider's participation is terminated by the Kentucky Medicaid Program, services provided after the effective date of termination are not payable.

SECTION III - CONDITIONS OF PARTICIPATION

907 KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medicaid Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;

2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;

3. Misrepresenting factors concerning a facility's qualifications as a provider;

4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or

5. Submitting false or questionable charges to the agency.

The Kentucky Medicaid Program shall notify a provider in writing at least thirty (30) days prior to the effective date of any decision to terminate, suspend, deny. or not renew a provider agreement. The notice will state:

I. The reasons for the decision;

2. The effective date;

3. The extent of its applicability to participation in the Medical Assistance Program;

4. The earliest date on which the Cabinet will accept a request for reinstatement;

5. The requirements and procedures for reinstatement; and

6. The appeal rights available to the excluded party.

The provider receiving such notice may request an evidentiary hearing. The request shall ~~must~~ be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Human Resources. When an evidentiary hearing is held, the provider is entitled to the following:

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;

2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;

3. Counsel representing the provider;

4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and

5. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the. final decision of the Cabinet for Human Resources. These procedures apply to any provider who has received notice from the Cabinet of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Kentucky Medicaid ~~Medical Assistance~~ Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medicaid ~~Medical Assistance~~ Program. Adverse action taken against a provider under Medicare shall be appealed through Medicare procedures.

F. Placement

Assistance with placement in nursing facilities can be obtained by contacting the local office of the Department for Social Services whose staff are knowledgeable regarding potential for placement in Kentucky facilities.

The Medicaid Program does not routinely make payment for services provided to Kentucky Medicaid recipients who are placed in out-of-state long term care facilities, e.g. nursing facilities (NF), intermediate care facilities for the mentally retarded and developmentally disabled (ICF/MR/DD) and mental hospitals.

G. Patient's Advance Directives

Effective December 1, 1991, Section 4751 of OBRA 1990 requires that adults eighteen (18) years of age or older receive information concerning their rights to make decisions relative to their medical care. This includes the right to accept or refuse medical or surgical treatment, the right to execute a living will, and the right to grant a durable power of attorney for his or her medical care to another individual.

A hospital shall give information regarding advance directives at the time of the individual's admission as an inpatient. Additionally, providers shall:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

(b) Provide written information to all adult individuals on their policies concerning implementation of these rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State law (whether statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

State law allows for a health care provider or agent of the provider to object to the implementation of advance directives. For additional information, refer to KRS 311.634 and KRS **311.982** or consult an attorney.

Please refer to Appendix XXI for copies of materials relating to the Advance Directive Law.

1) Description of Kentucky laws regarding the

a) Living Will Act
b) Health Care Surrogate Act
c) Durable Power of Attorney

2) Living Will Declaration

3) Designation of Health Care Surrogate

4) Advance Directive **Acknowledgement**

5) Protocol

The cost of reproducing these materials shall be Medicaid allowable cost for Medicaid-eligible individuals.

SECTION IV - PROGRAM COVERAGE

IV. PROGRAM COVERAGE

A. Inpatient Services

1. A maximum of fourteen (14) days per admission is payable for admissions on and after April 1, 1981. All admissions are subject to approval by the Medicaid Peer Review Organization (PRO). and shall be within the scope of covered services. The 'Medicaid Program pays for [the] either the date of admission or the first day [date] of eligibility, if later, but shall[can]not pay for the date of discharge; however, all covered ancillary charges incurred on the date of discharge shall [will] be allowed by the Medicaid Program.

   Effective July 1, 1989, the Kentucky Medicaid Program provides reimbursement, without durational limits, for medically necessary inpatient hospital services provided to Medicaid recipients under age one (1) in hospitals defined by the Department of Medicaid Services as disproportionate share hospitals. This means that for disproportionate share hospitals, recipients under age one (1) shall [will] not be limited to the regular maximum of fourteen (14) days. After age 1, coverage reverts to the 14 day maximum.

   Effective for services provided on and after July 1, 1991, by hospitals designated by the Kentucky Medicaid Program as disproportionate share hospital, recipients under age six (6) are eligible for medically necessary inpatient services without durational limits, regardless of any prior utilization of hospital services. After age 6, coverage reverts to the 14-day maximum.

   Effective for services provided on and after July 1, 1991, the Kentucky Medicaid Program shall provide reimbursement for medically necessary inpatient services, without durational limits, regardless of any prior utilization of prior services, for recipients under aqe one (1). Reimbursement is available irrespective of designation as a disproportionate share hospital. After aqe 1, services provided by non-disproportionate share hospitals reverts to the 14-day maximum.

Effective for services provided on and after March 4, 1991, hospitals are reminded that KRS 205.575 requires hospitals participating in the Hospital Indigent Care Assurance Program (HICAP) to provide medically necessary days of care in excess of Medicaid program limits to Medicaid recipients free of charge to the Medicaid Program or the recipient. HICAP only applies to inpatient hospital services provided to recipients by hospitals located within the state of Kentucky.

2. Inpatient admissions covered for eligible Program recipients are those primarily for treatment indicated in the management of any acute or chronic illness, injury, or impairment, and for maternity care.

3. Admissions for diagnostic purposes shall be [art] reimbursable only if the diagnostic procedures cannot be performed on an outpatient basis.

4. The Medicaid Program shall [~~can~~] make payment for Program recipients who are transferred from a greater facility to a lesser facility for a combined total of 14 benefit days.

   Reimbursement for admissions to the lesser facility shall be [~~is~~] subject to the policies and procedures governing admissions to acute care hospitals.

   The Medicaid Program shall [~~can~~] make payment to the greater acute care hospital for a maximum of 14 days for Program recipients who are transferred from a lesser acute care hospital to a greater acute care hospital, if the needed acute care cannot be provided at the "lesser" facility.

5. The Medicaid Program shall [can] make payment for readmissions within 30 days ONLY when an acute exacerbation of an existing condition occurs or when an entirely new condition develops.

6. The General Assembly, Regular Session 1978, passed legislation (House. Bill 179) which amended KRS 205.560. The law specifies the conditions for which the Medicaid Program can make payment for induced abortions, induced miscarriages, or induced premature births for Title XIX recipients. The services shall be considered covered, subject to other Program edits, if the physician certifies that in his or her professional judgement an induced abortion or miscarriage is necessary for the preservation of the life of the woman, and in the case of an induced premature birth, intended to produce a live viable child.

   The appropriate certification forms (MAP-235 or MAP-236), indicating the procedure used and signed by the physician, shall accompany all invoices requesting payment for these services.

7. Sterilizations shall be ~~are~~ reimbursable by the Medicaid Program only when in compliance with federal regulations (42 CFR 441.250) which are as follows:

   a. The consent form (MAP-250, Rev. 1/79) shall be signed by the recipient and the person obtaining the consent at least thirty (30) days in advance of the procedure being performed, except in cases of premature delivery and emergency abdominal surgery, in which cases only a seventy-two (72) hour waiting period is required. The expected date of delivery shall have been 30 days in advance of the date the consent was given. A maximum of one hundred and eighty (180) days shall elapse between the date the consent form is signed and the date on which the procedure is performed.

   b. The physician who performs the procedure shall sign and date the MAP-250 after the sterilization procedure is performed.

   c. The recipient shall be at least twenty-one (21) years of age at the time consent is obtained.

d. The recipient shall not have been legally declared mentally incompetent unless he or she has been declared competent for purposes which **include the** ability to consent to sterilization, **and shall** not be institutionalized. The fact that a facility is classified as an NF or ICF/MR is not necessarily determinative of whether persons residing therein are "institutionalized." A person residing in an NF or ICF/MR is not considered to be an "institutionalized individual" for the purposes of the regulations unless that person is either: (a) involuntarily confined or detained under a civil or criminal statute in one of those facilities; or (b) confined under some form of a voluntary commitment, and the facility is a mental hospital or a facility for the care and treatment of mental illness.

e. The recipient shall be advised of the nature of the sterilization procedure to be performed, of alternative methods of family planning, and of the discomforts, risks, and benefits associated with it. The recipient shall be advised that his or her consent to be sterilized can be withdrawn at any time and will not affect his or her entitlement to benefits provided by Federal funds.

f. Interpreters shall be provided when there are language barriers and special arrangements shall be made for **[handicapped individuals]** persons with disabilities.

g. To reduce the chances of sterilization being chosen under duress, a consent shall not be obtained from anyone in **labor or** childbirth, under the influence of alcohol or other drugs, or seeking or obtaining an abortion.

h. These regulations apply to medical procedures performed for the purpose of producing sterility.

i. Reimbursement **shall** [is] not be available for hysterectomies performed for sterilization purposes.

j. ALL applicable spaces of the MAP-250 shall be completed and the form shall accompany all claims submitted for payment for a sterilization procedure.

8. In those cases where a sterilization is performed in conjunction with another surgical procedure (e.g., cesarean section, cyst removal) and compliance with Federal regulations governing payment for the sterilization has not been met, the Kentucky Medicaid Program can only make payment for the non-sterilization procedure. It is necessary to disallow one-half of the following: operating room charge, anesthesia charge, and pathology charges. Hospitals which utilize an all inclusive rate reimbursement system shall deduct one (1) day's charges representing Room and Board and All Inclusive Ancillary Services. These charges shall be entered in the non-covered column of the UB-82 billing form, indicating non-payment for the actual sterilization procedure. In the event a sterilization procedure is performed concurrently with a delivery and compliance of the sterilization procedure with federal regulations is not documented, the disallowed components will be the total operating room charges and all other ancillary charges pertaining to the sterilization procedure. The delivery service is payable if the patient is an eligible recipient.

9. Title XIX funds can be expended for hysterectomies that are medically necessary only under the following conditions:

a. The person who secures the authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render her permanently incapable of reproduction; and

b. The individual or her representative, if any, has signed and dated the Hysterectomy Consent Form (MAP-251, Rev. 1/79).

This Hysterectomy Consent Form (MAP-251, Rev. 1/79) shall accompany all claims submitted for payment for hysterectomies, except in the following situations:

a. The individual is already sterile at the time of the hysterectomy; or

b. The individual requires a hysterectomy because of a life-threatening emergency in which the physician determines that prior acknowledgement is not possible.

The physician shall certify in writing either the cause of the previous sterility or that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgement was not possible. The physician shall also include a description of the nature of the emergency. This documentation shall accompany any hysterectomy procedure for which a Hysterectomy Consent form (MAP-251) was not obtained.

If the service was performed in a period of retroactive eligibility, the physician shall certify in writing that the individual was previously informed that the procedure would render her incapable of reproducing, or that one of the exempt conditions was met.

10. Private accommodations shall [~~will~~] be reimbursed by the Medicaid Program only ifmedically necessary and so ordered by the attending physician. The physician's orders for and description of reasons for private accommodations shall be maintained in the recipient's medical records. If a private room is the only room available, payment will be made until another room becomes available. If all rooms on a particular floor or unit are private rooms, payment will be made. Documentation of these cases shall be made available to the Program upon request.

11. Physical therapy is an aspect of restorative care which consists of the application of a complex and sophisticated group of physical modalities and therapeutic services to relieve pain, develop or restore functions, and maintain maximum performance. The Medicaid Program will make payment for these services (as an ancillary service) when the therapy is actively concerned with restoration of a lost or impaired function. For example, physical therapy treatments in connection with a fractured hip or back, or a CVA shall be directed toward restoration of a lost or impaired function during the early phase when physical therapy can be expected to be effective. After the condition has passed the acute phase and the medical services provided in a hospital are no longer needed, the need for physical therapy will not justify continued hospitalization. These services can be provided through the outpatient department of the hospital or in an extended care facility.

    a. Physical therapy shall be prescribed and directed by the attending physician.

    b. Physical therapy shall be provided by a licensed physical therapist or a registered physiotherapist.

    For purposes of general information and clarification, when a patient is receiving supervised exercises while receiving hospital care for conditions not involving impairment of a physical function, the services required to maintain him or her at a given level generally shall not constitute physical therapy services, and therefore, shall not qualify for reimbursement by the Medicaid Program. General supervision of exercises which have been taught to the patient also shall not qualify for payment by the Medicaid Program. These services shall constitute rehabilitative nursing care and shall be included in the administrative cost of the facility.

    These definitions apply to both inpatient and outpatient hospital care.

The hospital administrator is required to complete an MAP-346 and MAP-347 notifying the Medicaid Program that the facility has these therapists on its [their] staff. The MAP-347 shall be retained in the hospital staff and available for review by the Medicaid Program staff. The MAP-346 shall be submitted to the Medicaid Program any time the staff is changed. Mail to: Department for Medicaid Services, Provider Enrollment, 275 East Main Street, Frankfort, Kentucky 40621.

NOTE: Physical therapy services provided off-site in accordance with provisions of the Commission for Health Economics Control in Kentucky, are reimbursable only to licensed, participating rehabilitation hospitals.

12. Newborn hospital charges are billed on a separate claim from the mother's (baby's name and MOTHER'S Medical Assistance number are entered on the claim form). These services shall be billed to the Medicaid Program using Type of Bill **110** which represents a non-payment or zero pay bill. This applies to instate hospitals only. All out-of-state hospitals shall bill the Medicaid Program using TOB **111** because they are reimbursed at a percent of usual and customary charges without year end cost adjustment.

Effective for services provided prior to July 1, 1991, if it is determined to be medically necessary (certified by PRO) for the newborn to stay after the mother is discharged, payment may be made for a maximum of fourteen days after the mother's discharge. The baby shall be eligible for the Medicaid Program benefits and the service shall be billed under the baby's name and Medical Assistance number., The date of service will begin with the date of the mother's discharge.

Effective for newborn services provided ~~[on or after July 1 1989]~~ from July 1, 1989 through June 30, 1991, to recipient; in hospitals defined by the Department of Medicaid Services as disproportionate share hospitals shall~~[are]~~ not be limited to the fourteen (14) day maximum until age one (1). These services can be billed, without durational limits, for medically necessary inpatient hospital services beginning with the date of the mother's discharge. See Section VII for billing instructions.

Effective for services provided on and after July 1, 1991, if it is determined to be medically necessary for the newborn to remain in hospital after the mother's discharge, reimbursement shall be provided without durational limits until the recipient reaches age one (1) irrespective of designation as a disproportionate share hospital. The baby shall be eligible for Medicaid Program benefits and the services shall be billed under the baby's Medical Assistance number.

Effective for services provided on and after July 1, 1991, by hospitals designated by the Kentucky Medicaid Program as disproportionate share hospital, recipients under age six (6) are eligible for medically necessary inpatient services without durational limits, regardless of any prior utilization of hospital services. See Section VII for billina instructions.

Payment cannot be made for hospital services when the baby is retained awaiting adoption placement because the continued stay is not medically necessary.

NOTE: If the mother was ineligible for Medical Assistance at the time of the service but the newborn has a Medical Assistance Identification Card, the charges for the newborn can be billed on a UB-82 using the baby's own number. In this type case, Form Locator four (4) of the UB-82 shall contain code 111.

13. Gastric bypass surgery and other similar procedures, including the jejunoileal bypass procedure and gastric stapling, are considered possibly cosmetic procedures and therefore are payable only if they meet the following criteria:

    a. There is documentation that the recipient suffers from other conditions to an extent dangerous to his or her health, e.g. high blood pressure, diabetes, coronary disease, etc.

    b. There is documentation that all other forms of weight loss have been exhausted, with legitimate efforts on the part of the physician and recipient, i.e. dieting, exercise, and medication.

    c. There is documentation that the sources of weight gain have been identified and subsequently, treatment was attempted in accordance with the diagnosis.

    d. There is documentation that prior to the surgery at least one (1) other physician besides the surgeon has been consulted and has approved of the surgical procedure as a last resort of treatment.

    e. The recipient is at least 100 pounds over the maximum weight of his or her height and weight category as determined by the attending physician.

    It is necessary that the above information accompany each claim for these procedures.

14. Billing for services prior to discharge may be made only if a recipient has been hospitalized for the applicable fourteen days of Program coverage. At that ~~[such]~~ time, hospitals can submit an initial billing for the first fourteen days. After the recipient is discharged, the instate hospital can submit a final billing showing actual discharge date.

15. Admission kits.

16. Inpatient dental services for "high risk" recipients ONLY (those with heart disease, mental retardation, high blood pressure, etc.).

17. The Kentucky Medicaid Program recognizes the following durable appliances and supplies as covered items subject to audit as to medical necessity for appliance.

Taylor Back-Brace
Williams Back-Brace
Chair Back-Brace
Long Leg Brace
Short Leg Brace
Cervical Four-Poster Brace
Shoulder Abduction Brace
Lumbar-Sacro Corset
Colostomy Care Devices or Permanent Appliances
Ileostomy Care Devices or Permanent Appliances
Prosthetic Care Devices - Contiguous Tissue
Any Bag or Catheter Supply Necessary for the Day of Discharge
Insulin Pump
Jobst Garment
TED Stockings

18. Per federal regulation (42 CFR 441.12), laboratory tests which are routinely performed on admission are reimbursable only when specifically ordered by the attending physician or responsible licensed practitioner.

19. A hospital can make arrangements or contract with others to furnish covered inpatient items and services.

a. Where a hospital obtains laboratory or other services for its inpatients under arrangements with an independent laboratory, the laboratory shall be certified to meet the CONDITIONS FOR COVERAGE OF SERVICES OF INDEPENDENT LABORATORIES governing participation under Title XVIII of Public Law 89-97. In these cases where the Medicaid Program makes payment for hospital inpatient services provided to the recipient, receipt of payment by the hospital for those services (whether it bills in its own right or on behalf of those

furnishing the services) shall relieve the recipient and the Program of further liability.

b. When laboratory services are obtained for an inpatient of a hospital under arrangements with the laboratory of another participating hospital, receipt of payment by the first hospital for the services (whether it bills in its own right or on behalf of those furnishing the services) shall relieve the Program and the recipient of further liability.

c. Effective for services provided on or after September 1, 1992, any provider that bills the Medicaid Program for laboratory services shall be required to provide their Clinical Laboratory Improvement Act (CLIA) Certificate number.

20. Speech therapy is payable whenever it is prescribed and directed by the attending physician. The facility shall also have a licensed speech therapist on its [their] staff. The Hospital Administrator is required to complete an MAP 346 and MAP-347 notifying the Medicaid Program that the facility has speech therapists on its [their] staff. The MAP-346 form shall be completed and submitted to the Medicaid Program anytime the facility has a change in its staff. The MAP-347 shall be retained in the hospital's files and shall be available for review by the Medicaid Program.

21. For services provided prior to June 1, 1991, observation room services and emergency room services are payable on an inpatient claim only when the recipient is admitted through the outpatient department.

22. Admissions strictly for treatment of alcohol, drug and chemical dependency do not fall within the scope of covered Medicaid benefits unless an emergency situation exists. In this event, discharge to an appropriate treatment center shall occur upon stabilization.

23. Hospital-based physician services (Anesthesiology, Cardiology, Pathology, Radiology, Encephalography) are reimbursable by the Department when billed in accordance with

Program guidelines. Please refer to Section V for detailed information.

B. Non-Covered Inpatient Services

1. Days of stay in excess of fourteen days per admission. This does not apply to [~~disproportionate share~~] acute hospitals that are billing Medicaid for recipients with exceptionally high costs or long lengths of stay under age one (1); and under age six (6) for disproportionate hospitals.

2. Days of stay in excess of the number of days set by PRO (subject to the fourteen day total limit).

3. If the recipient is "on leave" (not an inpatient), those days when he or she is not an inpatient are NOT to be counted toward the fourteen day period. Payment shall [~~can~~]not be made for days when the recipient is "on leave?

4. Private duty nursing services.

5. Artificial limbs.

6. Personal services that are not medically necessary (examples: television, guest meals, telephone).

7. Any charge reflecting a service that is not a determined reimbursable cost by Title XVIII or Title XIX.

8. Late discharge fees.

9. Administratively necessary days as determined by the hospitals on binding review with the Peer Review Organization (PRO).

10. Services not within the scope of Program coverage regardless of PRO determinations.

11. Diagnostic admissions for procedures which could be performed on an outpatient basis.

12. Admissions for elective or cosmetic procedures are non-payable by the Medicaid Program. (If the attending physician feels the procedure is medically necessary, documentation to support the medical necessity shall be submitted to the Division of Program Services for consideration.

13. Routine physical exams.

14. Professional charges for physician services that are not hospital-based (Section V, Reimbursement).

15. Take-home drugs and supplies.

16. Occupational therapy.

17. Call back, stat and handling or processing fees, etc.

18. Observation room services and emergency room services covering services provided on and after June 1, 1991.

C. Outpatient Services

1. There are no limitations on the number of hospital outpatient visits or services available to Program recipients.

   The hospital outpatient services which can be covered are as follows:

   a. Diagnostic services as ordered by a physician

   b. Therapeutic services as ordered by a physician

   C. Emergency room services in emergency situations a5 determined by a physician. The recipient shall have contact with the physician.

d. Clinic visits, which are provided in an outpatient department owned and operated by the hospital, may be considered for payment. The clinic visit charge shall be billed separately and shall not include ancillary charges, blood tests, X-rays, etc.; therefore, any clinic visit charge shall be considerably less than an emergency room charge.

e. Minor surgical and radiological procedures.

f. Hospital-based physician services (Anesthesiology, Cardiology, Encephalography, Radiology, Pathology, Emergency Room physician ~~[Services]~~) are reimbursable as defined in Section V, Reimbursement.

2. Sterilization procedures are payable as an outpatient service according to Federal Regulations cited in IV.A.- Inpatient Services.

3. Induced abortions, induced miscarriages, or induced premature births are covered as an outpatient service according to the regulations cited in IV.A. - Inpatient Services.

4. The following biological and blood constituents are exceptions to item 0.3. and are PAYABLE in the outpatient department for services provided prior to July 1, 1990.

a. Rho (D) Immune Globulin (Human)
b. Anti-hemophilic Factor (AHF)
c. Rabies drug treatment
d. Chemotherapy for any blood or chemical dyscrasia (e.g. cancer, hemophilia)
e. Medications associated with renal dialysis treatments
f. Base IV solutions (without drug additives)
g. Tetanus toxoid
h. Cortison injections

Beginning with services provided on or after July 1, 1990, reimbursement is available for drugs administered in the outpatient department. Reimbursement is not available for take-home drugs or drugs which have been deemed less-than-effective by the Food and Drug Administration (FDA).

5. The hospital outpatient services listed previously shall be reasonable and necessary and related to the diagnosis and prescribed by, *or* in the case of emergency room services, determined to be medically necessary by a duly-licensed physician, or when applicable, a duly-licensed dentist, for the care and treatment indicated in the management of illness, injury, impairment or maternity care, or for the purpose of determining the existence of ~~[such]~~ an illness or condition in a recipient. Moreover, the services shall be furnished by or under the supervision of a duly-licensed physician, or when applicable, a duly-licensed dentist.

6. A hospital may make arrangements or contract with others to furnish covered outpatient items and services.

   a. Where a hospital obtains laboratory or other services for its outpatients under arrangements with an independent laboratory, the laboratory shall be certified to meet the CONDITIONS FOR COVERAGE OF SERVICES OF INDEPENDENT LABORATORIES governing participation under Title XVIII of Public Law 89-97. In these cases where the Medicaid Program makes payment for hospital outpatient services provided to the recipient, receipt of payment by the hospital for those services (whether it bills in its own right or on behalf of those furnishing the services) shall relieve the recipient and the Program of further liability.

   b. When laboratory services are obtained for an outpatient of a hospital under arrangements with the laboratory of another participating hospital, receipt of payment by the first hospital for the services (whether it bills in its own right or on behalf of those furnishing the services) shall relieve the Program and the recipient of further liability.

   c. Effective for services provided on or after September 1, 1992, any provider that bills the Medicaid Program for laboratory services shall be required to provide their Clinical Laboratory Improvement Act (CLIA) Certificate number.

7. Physical therapy is covered on an outpatient basis according to the regulations cited for inpatient services - Section IV, item #11.

8. Speech therapy is payable whenever it is deemed as a necessity by the physician. Refer to regulations cited for inpatient services - Section IV, Item #20.

9. Outpatient dental services for "high risk" recipients ONLY (those with heart disease, mental retardation, high blood pressure, etc.).

10. Observation room and holding beds.

D. Non-Covered Outpatient Services

The following outpatient services shall be [~~are~~] EXCLUDED from Program coverage:

1. Items and services which are not reasonable and necessary and related to the diagnosis or treatment of illness or injury, impairment or maternity care.

2. Services for which the recipient has no obligation to pay and for which no other person has a legal obligation to pay.

3. Drugs, biologicals and injectables purchased by or dispensed to a recipient for services provided prior to July 1, 1990, are not reimbursable by the Medicaid Program with the exception of those noted in C.4. [~~above.~~] (NOTE: These items may be provided under the pharmacy portion of the Medicaid Program, in accordance with the Medical Assistance Outpatient Drugs List.)

4. Routine physical examinations.

5. Charges less than $1.00.

6. Call back, stat and handling or processing fees.

7. Elective or cosmetic procedures are non-payable by the Medicaid Program. If the attending physician determines the procedure is medically necessary, documentation to support the medical necessity shall be submitted to the Division of Program Services for consideration. ~~(.)~~

8. Take home drugs and supplies.

9. Occupational therapy.

For outpatient services provided on and after July 1, 1990, reimbursement shall continue at sixty five (65%) percent of covered charges with limitations on reimbursement for laboratory services. The Department shall, however, cost settle to the lower of cost or charges at the year end for Kentucky hospitals.

Effective for services provided on and after June **1, 1991,** all outpatient services provided prior to the actual time of admission shall be submitted on a separate claim and shall not be combined and billed as an inpatient service.

D. Outpatient Laboratory Rates

For services provided to Medicaid recipients on and after October 1, 1984, the Deficit Reduction Act of 1984 requires hospital outpatient and nonpatient laboratory services to be paid in accordance with a fee schedule. Where a tissue sample, blood sample, or specimen is taken by personnel not employed by the hospital but the sample specimen is sent to the hospital for tests, the tests are not outpatient services since the patient does not directly receive services from the hospital. These are nonpatient laboratory services. There will be a separate fee schedule for outpatient laboratory services and a separate fee schedule for nonpatient laboratory services. All outpatient and non-patient laboratory procedures shall be coded using the Current Procedural Terminology Fourth Edition (CPT-4).

All outpatient and nonpatient laboratory procedures other than those excluded by Medicare are subject to the fee schedule limitations. Payment shall be the lower of usual and customary charges or the maximum on the fee schedule. The fee schedule, developed by the Medicare carriers, is established on a carrier wide basis, not to exceed a statewide basis.

Separate charges made by hospital laboratories for drawing or collecting specimens are allowable up to $3.00, whether or not the specimens are referred to hospitals or laboratories for testing. This is payable to the hospital only when its staff extracts the specimen from the recipient. Only one collection fee is allowed for each patient encounter regardless of the number of samples drawn. A specimen collection fee will be allowed ONLY in the following circumstances:

1. Procedure Code P9600 or 36415

   Drawing a blood sample through venipuncture (Example: inserting a needle with syringe or vacutainer into a vein to draw the specimen). A specimen collection fee will not be allowed for blood samples drawn from a capillary.

2. Procedure Code P5367

   Collecting a urine sample by catheterization.

Neither deductible nor coinsurance will apply to either outpatient or nonpatient laboratory services paid under the fee schedule by Medicare. Payment in accordance with the fee schedule is payment in full.

The CPT-4 books may be ordered from the following address:

~~[Book and Pamphlet Fulfillment: OPD54191]~~
Order Department, OPO 54192
American Medical Association
P.O. Box 10950 ~~[2964]~~
Chicago, IL 60610
~~[Milwaukee, Wisconsin 53201]~~

You may place your order by calling 1-800-621-8335. Your checks are to be payable to the American Medical Association.

E. Hospital-Based Physicians

Reimbursement for services provided by hospital-based physicians (where applicable to the provisions of the Medicaid Program) shall be in accordance with the PRINCIPLES OF REIMBURSEMENT FOR SERVICES BY HOSPITAL-BASED PHYSICIANS, HIM-6 under Title XVIII of Public Law 89-97.

The reasonable cost for all professional services provided to the Medicaid Program recipients by residents and interns under professionally approved training programs is an item of reimbursable cost to the hospital. These services, therefore, cannot be billed separately to the Medicaid Program.

SECTION V - REIMBURSEMENT

F. Professional Component of Hospital-Based Physicians

1. A physician is considered a hospital-based physician when he or she enters into a contractual arrangement with the hospital to provide a service for patients. The cost of salary or contract shall be recognized as a reimbursable cost by Title XVIII before it can be reimbursed by the Medicaid Program. The Medicaid Program applies the same definition to hospital-based physicians as does the Title XVIII Program as found in its PRINCIPLES OF REIMBURSEMENT FOR SERVICES [RENDERED] BY HOSPITAL-BASED PHYSICIANS (HIM-6).

2. The Medicaid Program shall require that hospitals who bill the Program for services provided to their[~~its~~] recipients by any or all of the hospital-based physicians maintain their records of the Medicaid Program payment on behalf of those physicians in a manner that the Program can obtain from hospital records exact information regarding amounts paid by the Medicaid Program on behalf of each physician.

3. The Medicaid Program shall make payment to the hospital for services of those physicians (for whom the hospital is billing the Medicaid Program) for professional patient care provided during and after the Program's covered hospital benefit days. This is the ONLY charge covered by the Program during days NOT payable by the Medicaid Program.

4. Only the following categories of practice (excluding emergency room physicians) are considered a reimbursable cost in which the professional component shall be reimbursed at 100% for services provided prior to July 1, 1988. Effective for services provided on and after July 1, 1988, reimbursement for outpatient professional component charges (excluding emergency room physicians), shall be at 65% of usual and customary charges. The maximum payment for emergency room physician services provided prior to July 1, 1990 is $35.00. Effective for services provided on and after July 1, 1990, the maximum payment of $35.00 was removed and reimbursement shall be at sixty-five (65%) percent of the usual and customary charge.

Anesthesiology
Cardiology
Pathology
Radiology
Encephalography
Emergency Room Physicians (outpatient only)

These physicians shall meet all of the following criteria:

a. Shall be salaried or in contractual arrangements with the hospital

b. Shall be recognizable Title XVIII costs

c. Shall be licensed physicians in their states of practice

d. Reimbursement for professional patient care services provided by those hospital-based physicians in the categories listed in Section V.E.4. to Program recipients shall be made to the hospital in accordance with the rates of payment for professional patient care services established between the physician and the hospital in their mutual contractual arrangement. The Medicaid Program shall allow 100% of the professional charges for cost purposes on inpatient services; however, the Medicaid Program payment covering these services shall be included in the hospital's prospective rate of reimbursement. Outpatient professional services shall be reimbursed by the Medicaid Program at an interim rate of 65% of usual and customary charges with year end cost settlement to the lower of cost or charges. These physicians SHALL NOT bill the Medicaid Program for these services under any other Program element.

5. The hospital administrator signs an MAP-346 listing the hospital-based physicians and their license numbers. The physician then signs an MAP-347 authorizing payment to the hospital for his or her services outlined in the contract. The actual contracts shall be available for review by the Medicaid Program. The administrators maintain responsibility for keeping the list of hospital-based physicians updated and the ~~[(]~~MAP-347~~[)]~~ shall be retained in the hospital's files. The MAP-346 shall be submitted to the Medicaid Program prior to billing for the service.

6. The charge for an emergency room physician is not a recognizable charge on the inpatient billing form. If the recipient is admitted, the charge for an emergency room physician visit shall be submitted on a separate UB-82 billing form as an outpatient service.

7. a. The hospital shall bill only for those services <u>provided</u> to recipients actually seen and treated by a hospital-based physician. Records shall be audited and the hospital shall be reimbursed only for services performed by those physicians shown on Program records.

   b. Periodically staff of the Medicaid Program shall survey hospitals for professional component billings. If the Medicaid Program has been billed and has paid for a physician service and if the recipient was not seen directly by the physician, a total refund shall be requested.

G. Hospital Component

1. The Medicaid Program shall reimburse the hospital at an approved prospective rate for days and services covered by the Program. The hospital shall bill the recipient ONLY for services and days NOT payable by the Medicaid Program. All monies paid except patient payments for non-covered items, by sources other than the Medicaid Program shall be entered in the space provided on the UB-82. Any amounts reported in excess of the noncovered services or days shall serve to reduce the Medicaid Program payment.

2. It shall [~~will~~] be the hospital's responsibility to obtain permission for release of information from the recipient upon admission to the hospital. This release of information will enable an authorized representative of the Department for Medicaid Services to have access to the recipient's medical record, if necessary.

H. Payment From Recipient

The Medicaid Program requires all hospitals that participate in the Program to report ALL payments or deposits made toward a recipient's account, regardless of the source of payment. In the event that the hospital receives payment from an eligible Medicaid Program recipient for a covered service, the Medicaid Program regulations preclude payment being made by the Program for that service unless documentation is received that the payment has been refunded. This policy does not apply to payments made by recipients for spend-down or non-covered services.

All items or services considered by the Medicaid Program to be non-covered which were provided to Medicaid recipients during any period of a covered service can be billed to the recipient or any other responsible party. The amounts covering these items shall not be listed on the UB-82 as an amount received from other sources.

I. Equal Charge

The charge made to shall be the same charge made for comparable services provided to any party or payor.

J. Duplication of Payment

A covered service shall be reimbursed only one time. Any duplication of payment by the Medicaid Program whether due to erroneous billing or payment system faults, shall be refunded to the Medicaid Program. The address is listed in Section VI-A, Item #E.

Failure to refund a duplicate or inappropriate payment shall be interpreted as fraud and abuse, and prosecuted as such.

K. Hospice Benefits

If a recipient is receiving benefits under the Kentucky Medicaid Hospice Program, payment for hospital services (inpatient or outpatient) related to the recipient's terminal illness shall be billed by the hospice agency. If the inpatient or outpatient service is NOT related to the terminal illness, the hospice agency shall submit to the hospital an Other Hospitalization Statement (form MAP-383) and the hospital shall bill the Medicaid Program for these services utilizing the UB-82 billing form and and attaching a copy of the MAP-383. Without the MAP-383 attached, these services shall be rejected by the Medicaid Program.

L. Days

1. For Medicaid purposes, a day is considered in relation to the midnight census.

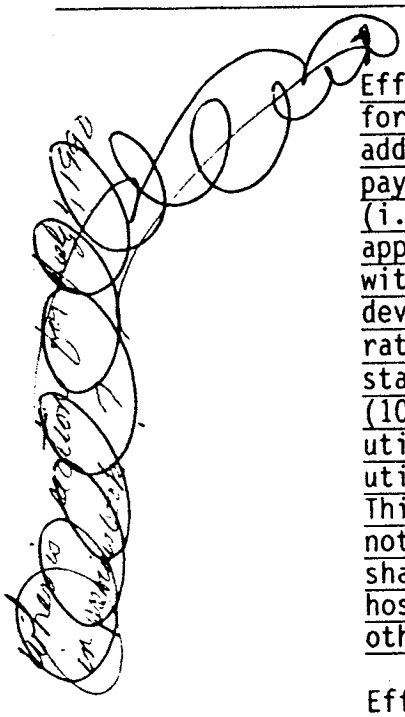
2. Medicaid shall pay the date of admission but shall not pay the date of discharge (death); however, all covered ancillary charges incurred on the date of discharge (death) shall be be Medicaid allowable covered charges.

3. Recipients or others shall not be billed for the date of discharge (death).

M. Reimbursement to Out-of-State Facilities

1. Inpatient Services

Effective for services provided on or after July 1, 1988, to June 30, 1990, reimbursement for out-of-state hospital inpatient services shall be seventy-five percent (75%) of usual and customary charges. Inpatient professional component services shall be reimbursed at one hundred percent (100%) of usual and customary charges.



Effective for services provided on or after July 1, 1991, for out-of-state disproportionate share hospitals, an add-on fee equal to $1.00 as an addition to a hospital payment rate computed using appropriate upper limits (i.e., the in-state median cost per diem for the appropriate peer group); and for out-of-state hospitals with Medicaid utilization in excess of one (1) standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, a further payment adjustment which is equal to ten (10) cents for each one (1) percent of Medicaid utilization in the hospital which is in excess of utilization at the one (1) standard deviation level. This add-on amount shall be applicable to all recipients, not just recipients under age six (6) in disproportionate share hospitals and shall begin on the first day of the hospital stay and not on the thirty-first 31st day like other disproportionate share claims.

Effective February 1, 1991, all inpatient professional component services shall be reimbursed at seventy-five percent (75%) of the usual and customary charge.

3. Outpatient Services

Effective July 1, 1988, hospital outpatient services are reimbursed at sixty-five percent (65%) of usual and customary charges. Hospital outpatient professional component services shall be reimbursed at sixty-five percent (65%) of usual and customary charge. Professional component charges for emergency room physician services provided prior to July 1, 1990 are limited to a maximum payment of $35.00. Effective for services provided on or after July 1, 1990, the maximum of $35.00 was removed and emergency room physician services shall be reimbursed at sixty-five percent (65%) of the usual and customary charge.

Reimbursement for outpatient and nonpatient laboratory procedures will be in accordance with the latest available Title XVIII (Medicare) fee schedule.

SECTION VI - REIMBURSEMENT IN RELATION TO MEDICARE

VI. REIMBURSEMENT IN RELATION TO MEDICARE

A. Deductible and Coinsurance for Hospital Services

1. The Medicaid Program recipients who are also eligible for inpatient-outpatient hospital or physician benefits under Title XVIII-Parts A and B (Hospital Insurance and Supplementary Medical Insurance) shall be required to utilize their benefits under Title XVIII prior to the availability of inpatient-outpatient hospital and physician benefits under the Medicaid Program.

   The Medicaid Program shall make payments on behalf of those Title XIX recipients who are also entitled to benefits under Title XVIII-Part A of Public Law 89-97. The Medicaid Program shall pay the in-hospital deductible, blood deductible, or coinsurance amounts as determined by Medicare. The coinsurance amount for the 61st - 90th day is 1/4 of the applicable deductible amount, and for the 91st - 150th Life Time Reserve Days it is 1/2 the applicable deductible amount.

   Section 301 of the Medicare Catastrophic Coverage Act of 1988 [~~(MCAA)~~] (MCCA) requires states to provide Medicaid coverage to certain Medicare beneficiaries in order to pay Medicare cost-sharing expenses (premium, deductible and coinsurance amounts). Individuals who are entitled to Medicare Part A and who do not exceed federally-established income and resources standards shall be known as Qualified Medicare Beneficiaries (QMB's).

   The Technical and Miscellaneous Revenue Act of 1988 (TAMRA) further provides that some individuals will have dual eligibility for QMB benefits and regular Medicaid benefits.

   When requesting payment for deductible or coinsurance days due under Title XVIII-Part A for inpatient services provided to Program recipients, the Medicare Check Remittance Advice or Medicare EOMB shall be attached to the UB-82.

2. The Medicaid Program shall make payment of the inpatient deductible or coinsurance for those days the recipient is Medicaid or QMB eligible. Whether the Medicaid Program makes payment at the hospital's Title XIX prospective rate, or payment of deductible and coinsurance, or a combination of the two, shall depend upon the extent of the recipient's unused Title XVIII-Part A benefits. Computation and payment of the deductible or coinsurance shall be made by the Medicaid Program in accordance with the usual Program computation procedures.

   If the recipient has utilized his or her 90 benefit days and his or her 60 day "lifetime reserve" under Title XVIII - Part A, but has not begun a new spell of illness as defined under Title XVIII when readmission becomes necessary, the Medicaid Program shall make payment at the hospital's Title XIX prospective rate for up to 14 days, if PRO certification is obtained.

   If the recipient chooses not to utilize their Life Reserve Days under Title XVIII-Part A, the Medicaid Program shall not make payment as all Medicare benefits were not exhausted. Payment for services shall then remain the recipient's responsibility.

3. The Medicaid Program shall make payment of the recipient's blood deductible. There is no maximum on the amount per unit; however, Title XIX reimbursement is limited to three (3) units. Medicare, Title XVIII, shall be responsible for all remaining units used.

4. The Medicaid Program shall pay Part B deductible and coinsurance for hospital services (including the blood deductible) for recipients, in accordance with the Medicaid Program benefits, policies and procedures.